The Senate

Finance and Public Administration References Committee

Council of Australian Governments Reforms Relating to Health and Hospitals

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42nd Parliament

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Table of Contents

Chapter 1

The terms of the inquiry

Background to the inquiry

1.1 On 13 May 2010, the Senate referred to the Finance and Public Administration References Committee for inquiry and report by 18 June 2010 (subsequently extended to 21 June and then 23 June 2010):

> The key outcomes agreed by the Commonwealth Government and five states and two territories at the Council of Australian Governments (COAG) meeting on 19 April and 20 April 2010 and the process of consultation between the states and Commonwealth prior to these agreements and related matters, including but not limited to:
>
> (a) the new financial arrangements between the Commonwealth and states and territories over the forward estimates and the conditional requirements upon the states for receipt of additional Commonwealth funding;
>
> (b) 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;
>
> (c) the projected number of additional/new services this additional funding will provide in elective surgery treatments, in emergency department treatments, in expected numbers of patients to sign up to the diabetes spending measure, in additional general practitioner (GP) treatments in aged care facilities, including the inputs, assumptions and modelling underpinning these projections;
>
> (d) the $15.6 billion top-up payments guaranteed to the states by the Commonwealth in the period 2014–15 to 2019–20, including exploring the breakdown of expenditure relating to hospitals, outpatient services, capital expenditure, GP and primary healthcare, aged care and other areas of health expenditure;
>
> (e) the names, roles, structures, operations, resourcing, funding and staffing of any new statutory bodies, organisations or other entities needed to establish, oversee, monitor, report upon or administer the National Health and Hospital Networks, Primary Care Organisations and the funding channels to be established under the COAG agreements;
>
> (f) what arrangements are in place, or are being negotiated for states that have not signed up, nor fully signed up to the COAG agreements,

including what contingencies have been put in place for states that may want to alter agreements in future;

(g) the intent of the state and territory governments and their preferred number and size of Local Hospital Networks in each state and territory;

(h) the number of hospitals which will receive: activity-based funding, block grant funding, or a mix of both;

(i) aged care:

(i) the 2,500 new aged care beds to be generated by zero interest loans,

(ii) the 2,000 beds for long stay older patients to be established,

(iii) the funding for the above, and

(iv) the establishment of the Commonwealth Government as responsible for full funding, policy, management and delivery responsibility for a national aged care system;

(j) mental health matters; and

(k) any other related matter.

Conduct of the inquiry

1.2 The inquiry was advertised in *The Australian* and through the Internet. The committee invited submission from the Commonwealth Government, state and territory governments and interested organisations and individuals.

1.3 The committee received 37 public submissions. A list of individuals and organisations that made public submissions to the inquiry together with other information authorised for publication is at Appendix 1. The committee held two days of hearings in Canberra on 7 June and Melbourne on 8 June 2010. Appendix 2 lists the names and organisations of those who appeared. Submissions, additional information received including answers to questions on notice and the Hansard transcript of evidence may be accessed through the committee's website at: http://www.aph.gov.au/senate/committee/fapa_ctte/index.htm.

Acknowledgement

1.4 The committee thanks those organisations and individuals who made submissions and gave evidence at the public hearing.

Structure of the report

1.5 The committee's report is structured as follows:

- Chapter 2 provides an overview of the COAG reforms relating to health and hospitals;

- Chapter 3 considers the adequacy of the COAG health reforms and looks at the first eight terms of reference;
- Chapter 4 examines term of reference (i) concerning aged care;
- Chapter 5 addresses term of reference (j) concerning mental health matters;
- Chapter 6 considers term of reference (k) concerning any other matters and considers issues including oral and dental health, Indigenous health and the e-health initiative; and
- Chapter 7 contains the committee's conclusions.

Note on references

1.6 References to the Committee Hansard are to the proof Hansard: page numbers may vary between the proof and the official Hansard.

Chapter 2

COAG health and hospital reforms

2.1 The breakdown of funding for the Council of Australian Governments (COAG) health and hospital reforms has been taken principally from the Budget papers, media releases and COAG communiqués.

Background

2.2 At its 29 November 2008 meeting, COAG agreed on several initiatives regarding health.

2.3 As part of the $64 billion agreement for health and hospital funding, the states and territories agreed to national outcomes and outputs, new targets and increased service levels.[1]

2.4 On 3 March 2010, the Commonwealth Government announced major reforms to the country's health and hospital system. The Rudd Government described them 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'.[2]

2.5 The reforms were supposedly 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.

2.6 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 requiring the states to forego one third of GST revenue;
- taking over responsibility for all GP and primary health care services;
- establishing Local Hospital Networks (LHN);

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

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

- funding hospitals on activity bases, for services they deliver, rather than simply block funding grants; and
- bringing fragmented health and hospital services together under a single National Health and Hospitals Network, through strong transparent national reporting.[3]

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

2.8 On 12 April, *A National Health and Hospitals Network: further investments in Australia's Health*, representing stage two of the Government's National Health Reform Plan was launched. This provided additional funding in a range of areas leading up to the 19th and 20th April COAG meeting.

2.9 Finally after the COAG meeting on 19th and 20th April, *A National Health and Hospitals Network for Australia's Future: delivering better health and better hospitals* was launched.

2.10 On 4 March, Western Australian Premier, the Hon Colin Barnett MLA, was reported as saying that the Commonwealth's proposal to increase its contribution to health by taking money from the states was a 'sleight of hand', 'very unsatisfactory' and unachievable without the co-operation of the states. The report also stated that:

> "We will not tolerate a situation where, from Canberra, all the decisions relating to our hospitals and most of the healthcare decisions are made," [Mr Barnett] said.
>
> Mr Barnett while he did not want to get into "a pathetic little argument" about who pays what, the federal government was set to use state money as commonwealth funding.
>
> "To say the commonwealth is going to fund 60 per cent, well no it's not, it's actually taking another 15, 20 per cent off the states," Mr Barnett told Fairfax Radio Network today.
>
> "So it's using state money to try and say this is commonwealth funding."
>
> Mr Barnett said a jointly administered national pool contributed to by the commonwealth and the states had merit but the notion of a commonwealth takeover did not.[4]

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3 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).

4 Paige Taylor and Sid Maher, 'WA says no, other states give cautious support to Rudd health reforms', *The Australia*, 4 March 2010, http://www.theaustralian.com.au/politics/wa-says-no-other-states-give-cautious-support-to-rudd-health-reforms/story-e6frgczf-1225836717944 (accessed 10.6.10).

2.11 In a subsequent radio interview Mr Barnett commented:

> I think there is real hope that at COAG that we could agree on a pooling of funds. I think we can agree on activity-based funding. We could possibly agree on the model of governance of our public hospitals. [But] the suggestion to the states to simply give away the GST, I just don't think that is realistic.[5]

2.12 On 7 March, the NSW Premier, the Hon Kristina Keneally MP, called for more information on the proposed health reforms package.[6] It was reported that the Premier had written to the Prime Minister seeking full information regarding the reforms. *The Australian* reported:

> "In order to achieve the right outcomes at our next COAG meeting, we need to know more about your plans to reform other aspects of the health system, in particular the primary care system," [the Premier] said.
>
> The NSW Premier also expressed doubts about many aspects of the funding arrangements which will see 30 per cent of GST revenue stripped from the states to bankroll the new National Health and Hospital Network.
>
> She identified significant establishment costs would be incurred to move NSW to a local Health Network Model, predicting the creation of up to 25 bodies across the state.
>
> "Could you please advise whether these establishment costs have been factored into any calculations of the financial impact of the reforms on the states and territories?" she asked.
>
> The Premier also expressed concern for smaller and regional hospitals which may not be able to deliver services at an efficient price.[7]

2.13 The Victorian Government was reported as being opposed to the proposed reforms. The Victorian Government released a list of 10 'sticking points'. However, the Victorian Premier, the Hon John Brumby MLA, stated on 30 March that the list was 'well in excess of 40 questions'.[8] The Premier put forward an alternative funding plan for a state-based pool of money, contributed by the states and the Commonwealth

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5 Joe Kelly, 'Colin Barnett opposes Kevin Rudd's GST plan to fund health reforms', *The Australian*, 24 March 2010, http://www.theaustralian.com.au/politics/colin-barnett-opposes-kevin-rudds-gst-plan-to-fund-health-reforms/story-e6frgczf-1225844704675 (accessed 10.6.10).

6 Stephanie Peatling and Joel Gibson, 'PM delivers ultimatum to the states', *Sydney Morning Herald*, 7 March 2010, http://www.smh.com.au/national/pm-delivers-ultimatum-to-the-states-20100306-ppp9.html (accessed 10.6.10).

7 Joe Kelly, 'Keneally threatens Rudd over health reform support at COAG', *The Australia*, 5 March 2010, http://www.theaustralian.com.au/politics/keneally-threatens-rudd-over-health-reform-support-at-coag/story-e6frgczf-1225837313310 (accessed 10.6.10).

8 Transcript of John Brumby interview in 'Rudd, states continue hospital reform talks', *Lateline*, ABC Television, 30 March 2010, http://www.abc.net.au/lateline/content/2010/s2860706.htm (accessed 10.6.10).

which he described as 'more transparent, it's more open, it's more accountable, it will drive better performance'.[9]

2.14 The new financial arrangements between the Commonwealth and the states and territories were discussed at the meetings of Heads of Treasury on 12 March 2010; Deputy Heads of Treasury on 18 March 2010; and Ministerial Council on Federal Financial Relations on 26 March 2010.[10]

2.15 Victorian Premier John Brumby responded to the Prime Minister's threat of a referendum by releasing his own health scheme to state and federal leaders as an alternative to the Commonwealth reforms.[11] On 9 April, Mr Brumby was reported to have said that three-quarters of the benefits to the health system would not arrive until 2017 and that the Commonwealth's plan to fund local hospital networks directly would create a 'parallel commonwealth bureaucracy'.[12] He further noted on 14 April during a National Press Club of Australia address:

> I don't believe that the Commonwealth plan has the right measures to improve our hospitals and improve our health care system.[13]

2.16 During the same address, Mr Brumby also stated:

> We've got a GST clawback that adds no new money to the system. We've got a health system that's proposed to be run out of Canberra and it's for those two fundamental reasons that Victoria cannot and will not support the Commonwealth proposal.
>
> At no time ever ever, formally, informally, on the record, off the record, in meetings, out of meetings, has there ever been any suggestion from the Prime Minister that they would steal the GST from the states. I mean that one just came straight out of the blue.

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9 Ben Packham, 'Victoria fundamental disagreement with Commonwealth over hospital reforms, Premier John Brumby says', *Herald Sun*, 31 March 2010, http://www.heraldsun.com.au/news/victoria-fundamental-disagreement-with-commonwealth-over-hospital-reforms-premier-john-brumby-says/story-e6frf7jo-1225848040574 (accessed 10.6.10).

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

11 Sid Maher, 'John Brumby challenges Kevin Rudd's health takeover with own reform plan', *The Australian*, 8 April 2010, http://www.theaustralian.com.au/politics/john-brumby-challenges-kevin-rudds-health-takeover-with-own-reform-plan/story-e6frgczf-1225851440653 (accessed 10.6.10).

12 Sid Maher and Milanda Rout, 'Hospitals take over on critical list', *The Australia*, 9 April 2010, http://www.theaustralian.com.au/politics/hospitals-takeover-on-critical-list/story-e6frgczf-1225851598424 (accessed 10.6.10).

13 The Hon John Brumby, Premier of Victoria, quoted in 'Brumby won't be bullied into hospital plan', Interview with Samantha Hawley, *PM, ABC Radio*, 14 April 2010, http://www.abc.net.au/pm/content/2010/s2872973.htm (accessed 10.6.10).

COAG meeting 19 and 20 April 2010

2.17 The reforms were then to be put to the states and territories at a COAG meeting on 19 April 2010. The negotiations, which continued into 20 April, focused primarily on the expressed concerns of Western Australia, New South Wales and Victoria regarding the Commonwealth's proposal to become the dominant funder of hospitals.[14] The three states agreed to allocate 30 per cent of GST funds to a pooled fund of federal and state money rather than allow the Commonwealth to take back a third of state GST revenue to directly fund 60 per cent of hospital costs.[15] The three states were reluctant, therefore, to make changes to the 2008 *Intergovernmental Agreement on Federal Financial Relations* which states that the Commonwealth 'will make GST payments to the States and Territories equivalent to the revenue received from the GST'.[16]

2.18 However, both NSW and Victoria recanted their earlier statements and reached an agreement with the Commonwealth on 20 April that the GST funds would be put into a fund pool and used by the states exclusively for health.[17] Amendments are required to the *Federal Financial Relations Act 2009* to reflect the new payment arrangements under the National Health and Hospitals Network Fund.[18] Amendments are required to the Intergovernmental Agreement to reflect the *National Health and Hospitals Network*.[19]

2.19 Under the agreement, a National Funding Authority was to be established for the purposes of distributing the funds to state funding authorities and then Local Hospital Networks (LHNs). However, on 16 June 2010, in an answer to a question on notice, the Government informed the committee that the National Funding Authority would not be established. Under the new arrangements, the Treasury will distribute the funds.[20]

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14 Sid Maher, 'Kevin Rudd stares down states on health funding', *The Australia*, 19 April 2010, http://www.theaustralian.com.au/politics/rudd-stares-down-states-on-health/story-e6frgczf-1225855230650 (accessed 14.5.10).

15 Emma Rodgers, 'Health Reform talks drag on', *ABC News*, 20 April 2010, http://www.abc.net.au/news/stories/2010/04/20/2877921.htm (accessed 14.5.10).

16 Council of Australian Governments, *Intergovernmental Agreement on Federal Financial Relations*, 2008, Part 4, Clause 25, p. 7.

17 Emma Rodgers, 'Health Reform talks drag on', *ABC News*, 20 April 2010.

18 Australian Government, *Budget Paper No. 3, 2010–11*, p. 167.

19 Australian Government, *Budget Paper No. 3, 2010–11*, p. 8.

20 'Government axes health fund watchdog', *ABC News*, http://www.abc.net.au/news/stories/2010/06/17/2929103.htm (accessed 21.6.10).

Funding arrangements

2.20 Under the National Health and Hospitals Network (NHHN) funding model, the Commonwealth Government claims it will become the major funder of the Australian public hospital system by funding:

- 60 per cent of the national efficient price of every public hospital service provided to public patients with the mechanisms yet to be determined;
- 60 per cent of recurrent expenditure incurred by states and territories on research and training functions undertaken in public hospitals;
- 60 per cent of block funding paid against a COAG-agreed funding model, including for agreed functions and services and community service obligations required to support small regional and rural public hospitals;
- 60 per cent of capital expenditure, on a 'user cost of capital' basis where possible; and
- over time, up to 100 per cent of the national efficient price of 'primary health care equivalent' outpatient services provided to public patients.[21]

2.21 In relation to the funding arrangements, the COAG communiqué stated:

> The Commonwealth and all States, apart from Western Australia, agreed that from 1 July 2011, an agreed amount of GST revenue will be retained and allocated by the Commonwealth to health and hospital services. Each State's retained GST will be allocated to health and hospital services in that State. This will be revenue-neutral for States. The amount of GST to be retained and allocated to health and hospitals will then be fixed from 2014-15, based on 2013-14 costs.
>
> Under this arrangement, the Commonwealth's funding contribution will be paid into a National Health and Hospitals Network Fund.
>
> Joint intergovernmental authorities ('Funding Authorities') which are State-based will receive funds from both the Commonwealth (through the National Health and Hospitals Network Fund) and State governments, and will directly pay Local Hospital Networks on an activity basis for public hospital services.[22]

Western Australia

2.22 The WA Premier, the Hon Colin Barnett MLA, refused to become a signatory to the COAG health reforms agreement stating that whilst he agreed with some of the

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21 Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation, and the Treasury, *Submission 24*, p. 2; Hawker Britton, *National Health and Hospitals Network (NHHN)*, 3 March 2010, http://www.hawkerbritton.com/hawker-britton-media/federal-act/333/national-health-and-hospitals-network-nhhn.htm (accessed 21.5.10).

22 Council of Australian Governments, *Council of Australian Governments Meeting 19 and 20 April 2010, Communiqué*, pp 5–6.

details of the reform package, he rejected the proposal that the Commonwealth retain 30 per cent of the state's GST. Mr Barnett indicated that he was prepared to pay an equivalent amount into the new health fund created under the agreement, he raised concerns about the Commonwealth retaining the GST revenue and stated:

> …for one third of the total GST collections to go into this health pool, means Western Australia will be contributing about 60 per cent of its GST into the pool. Now, we're prepared, in principle, to do that so long as it is Western Australia paying into the pool, not the Commonwealth taking away a State taxation revenue source.[23]

2.23 Whilst the WA Government and Commonwealth continue negotiations on the health reforms, WA will continue to be funded through the existing National Healthcare Special Purpose Payments (SPP) arrangements. The Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation, and the Treasury, commented:

> The Government is continuing negotiations with Western Australia to seek their agreement to the reforms agreed by five states and two territories at the COAG meeting of 19 and 20 April 2010, to ensure that people in Western Australia receive the full benefits the National Health and Hospitals Network will deliver.[24]

2.24 On 17 June 2010 it was reported in *The Australian* that:

> Western Australia may still get $350 million in new federal health funding, even if the Barnett government refuses to sign up to the Prime Minister's hospital reform package. The Rudd government originally insisted its failure to strike a deal with Western Australia would mean the state missing out on $350m in health funding over four years, but today appeared to be softening its hardline stance. Western Australia was the only state or territory not to sign up to the $50 billion health reform agreement at April's Council of Australian Governments meeting. Federal Health Minister Nicola Roxon said today she thought it was likely there would be a "stand-off for some time" over the issue between the commonwealth and Colin Barnett's Liberal government. However she conceded the government was looking at other ways the $350m could flow through to WA, saying she would not penalise its people.[25]

2.25 In evidence given to the Finance and Public Administration Legislation Committee during Budget Estimates, the Government confirmed that 'negotiations'

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23 The Hon Colin Barnett, Premier of Western Australia, 'Federal health plan', *ABC Radio National*, Transcript, 19 April 2010, http://www.premier.wa.gov.au/Ministers/Colin-Barnett/Documents/transcripts/transcriptCBarnett_2010041903.pdf (21.5.10).

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

25 Joe Kelly, 'Roxon backs away from withholding health funding from WA', *The Australian*, 17 June 2010, http://www.theaustralian.com.au/news/roxon-backs-away-from-withholding-health-funding-from-wa/story-e6frg6n6-1225880857894 (accessed 22.6.10).

between the Commonwealth and Western Australia could not include the Commonwealth moving from the position it had agreed with the five other states.

> Mr Rimmer—I was simply using a generic word to refer to ongoing discussions and consultations. In the process of that we are hoping to explain some aspects of the deal more effectively to our colleagues in Western Australia at a bureaucratic level. But you are quite right: 'negotiations' is perhaps a poor choice of word to have used.[26]

Roles and responsibilities between the Commonwealth and states excluding Western Australia

Public Hospitals

2.26 In funding terms, the Commonwealth will fund 60 per cent of the national efficient price of public hospital services delivered to public patients. According to COAG, the national efficient price is an 'independent and objectively determined calculation of the cost of providing public hospital services' but no further detail of this has been provided.[27] The Commonwealth will also provide 60 per cent of capital, research and training in public hospitals, and over time, move to fund 100 per cent of the national efficient price of 'primary care equivalent' outpatient services.

2.27 The states and territories (excluding WA) will retain responsibility for management of public hospitals and will be the single purchasers, through Service Agreements, of all public hospital services to be delivered by Local Hospital Networks (LHN).[28] The states will be responsible for meeting the remaining costs of public hospital services. Overall the signatory states and territories will:

- continue to own public hospitals;
- be responsible for all aspects on industrial relations policy and employment of the public hospital workforce; and
- continue their responsibility for the delivery of essential health related services such as ambulances and patient-assisted travel schemes.[29]

2.28 In accordance with the *National Health and Hospitals Network Agreement*, the Independent Hospital Pricing Authority (to be established under the reforms) will provide advice to COAG on the definition and typology of public hospitals eligible for block funding only; mixed activity based funding and block funding; and activity

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26 Senate Finance and Public Administration Legislation Committee, Mr B Rimmer, Department of the Prime Minister and Cabinet, *Committee Hansard*, 25.05.10, p. F&PA 60.

27 Council of Australian Governments, *Council of Australian Governments Meeting 19 and 20 April 2010, Communiqué*, p. 3.

28 Council of Australian Governments, *Council of Australian Governments Meeting 19 and 20 April 2010, Communiqué*, p. 3.

29 Australian Government, *A National Health and Hospitals Network for Australia's Future*, March 2010, p. 35.

based funding only. COAG will determine the number of hospitals that will receive activity-based funding, block grant funding, or a mix, based on such advice.[30] However no criteria for these decisions have been determined or made available.

Local Hospital Networks

2.29 As part of efforts to devolve operational management for public hospitals and accountability for delivery to the local level, Local Hospital Networks (LHNs) will be established. These will 'be established as separate legal entities under state or territory legislation'.[31]

2.30 Comprising single or small groups of public hospitals with a geographic or functional connection and organised along state borders, the LHNs will be responsible for making decisions on the day-to-day operations within their Network (including managing budgets and planning to deliver services in accordance with their annual service agreements with the state or territory.[32]

2.31 The Commonwealth will fund the LHNs directly through the hospital services they provide via activity based funding. However, according to COAG, the Commonwealth will play no role in the negotiation or implementation of LHN Service Agreements.[33] This will remain the province of the states and territories.

2.32 The Commonwealth and the states and territories have agreed that the NHHN should be delivered 'with no net increase in bureaucracy as a proportion of the ongoing health workforce'. The Commonwealth Government expects that LHNs will be established by state and territory governments within current health department staffing levels.[34]

2.33 The involved states and territories will be primarily responsible to determine the number and location of the LHNs. The NHHN Agreement signed at COAG on 20 April 2010 states that 'the final number and boundaries of Local Hospital Networks will be primarily a matter for states and territories to resolve, with the number and

30 Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation, and the Treasury, *Submission 24,* p. 10.

31 Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation, and the Treasury, *Submission 24,* p. 6.

32 Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation, and the Treasury, *Submission 24,* p. 6.

33 Council of Australian Governments, *Council of Australian Governments Meeting 19 and 20 April 2010, Communiqué,* p. 3.

34 Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation, and the Treasury, *Submission 24,* p. 6.

boundaries to be resolved bilaterally between the Prime Minister and Premiers or First Ministers, as appropriate, by 31 December 2010'.[35]

2.34 A number of submitters raised concerns about the LHNs, of which the fact that they will not be fully integrated with other parts of the health system was central. This and other concerns regarding the LHNs are considered in Chapter 3.

Primary Health Care and Aged Care

2.35 The Commonwealth will have full funding and policy responsibility for GP and primary health care under the *National Health and Hospitals Network Agreement* except in WA. Community health centres, primary mental health care, immunisation, and cancer screening programs fall under Commonwealth responsibilities. According to COAG, the Commonwealth will introduce primary health care organisations responsible to improve the integration of services and reduce access gaps. Current service delivery arrangements will remain in place for a five year period unless otherwise agreed by governments.[36]

2.36 The Commonwealth will also have full funding and policy responsibility for aged care except in WA and Victoria. Such reforms include the transfer of current resourcing for aged care services from the Home and Community Care (HACC) program (except in Victoria) to the Commonwealth.[37]

Conditional requirements of signatory states and territories to the National Health and Hospitals Network

2.37 Key conditional requirements on the signatory states and territories for receipt of additional Commonwealth funding are set out in the *National Health and Hospitals Network Agreement* which requires that they:

- establish Local Hospital Networks;
- establish a National Health and Hospitals Network Funding Authority as a joint intergovernmental authority which is state/territory based with a board of supervisors (comprising one member from the respective state/territory, one from the Commonwealth, and an independent chair chosen jointly);
- provide data to the Independent Hospital Pricing Authority on state funding contributions towards public hospital services provided by Local Hospital Networks under Local Hospital Network Service Agreements and other data

35 Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation, and the Treasury, *Submission 24,* p. 9.

36 Council of Australian Governments, *Council of Australian Governments Meeting 19 and 20 April 2010, Communiqué,* p. 4.

37 Council of Australian Governments, *Council of Australian Governments Meeting 19 and 20 April 2010, Communiqué,* p. 4.

necessary for the calculation of the national efficient and state or territory specific prices;

- maintain their current level of effort in the delivery of GP and primary health care services; and
- ensure that appropriate levels of health expenditure (including hospital capital investment and funding) are maintained until the end of 2013–14.[38]

2.38 Little detail on the means of ensuring compliance with this has been provided.

Medicare Locals

2.39 The Commonwealth will establish primary health care organisations known as Medicare Locals.

2.40 Concerns raised in evidence before this inquiry regarding Medicare Locals are considered in Chapter 3.

Aged care

2.41 The Commonwealth will take funding and regulatory responsibility for aged care services for older Australians (aged 65 years and over, and 50 years and over for Aboriginal and Torres Strait Islander people) except for Health and Community Care (HACC) in Victoria.

2.42 Given that the Commonwealth Government is already the predominant funder of aged care in Australia, the effect of this measure is simply the take over of the existing 40 per cent state and territory contribution for HACC except for Victoria.

Mental health

2.43 The Commonwealth will take full funding and policy responsibility for primary mental health care services for common mild to moderate disorders such as anxiety and depression, including those services currently provided by states and territories (except Western Australia).[39]

2.44 Concerns in relation to the adequacy of mental health funding and the ability of such funding to achieve stated targets are addressed in Chapter 5.

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

39 Departments of Health and Ageing, the Prime Minister and Cabinet, Finance and Deregulation, and the Treasury, *Submission 24*, p. 11.

Electronic Health Records

2.45 The Commonwealth will also provide $466.7 million over two years to establish the key components of the personally controlled electronic health record system.[40]

2.46 The funding will establish a system of personally controlled electronic health records that will provide summaries of patients' health information including medications and immunisations and medical test results.[41]

Government Advertising

2.47 The Commonwealth will spend $29.5 million on a national communications campaign to inform Australians about the changes and improvements to health services under the NHHN.[42]

2.48 In view of the evidence presented, there are concerns that the advertising campaign is misleading and deceptive in that it does not properly reflect the parameters of the reform, most especially the 'federally funded, locally run' assertion.

2.49 Concerns about the campaign will be raised separately.

New statutory bodies, organisations and other entities

2.50 The NHHN will be supported by several new authorities including:

- National Health and Hospitals Network Funding Authorities;
- Independent Hospital Pricing Authority;
- National Performance Authority;
- Australian Commission on Safety and Quality in Health Care;
- Local Health Networks; and
- Medicare Locals.

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40 Australian Government, *Budget Paper No. 2, 2010–11*, p. 225.

41 The Hon Nicola Roxon MP, Minister for Health and Ageing, *'Personally Controlled Electronic Health Records for all Australians', Media Release,* 11 May 2010, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/03320F4F974E6714CA25772200030C01/$File/hmedia09.pdf (accessed 25/5/10).

42 Australian Government, *Budget Paper No. 2, 2010–11*, p. 224.

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.
>
> 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.
>
> 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.

Chapter 4

Aged care

Introduction

4.1 In residential aged care, stakeholders raised concerns over planning in relation to the Commonwealth assuming responsibility for the sector, the longer-term viability of the sector, and funding gaps between the cost of providing care and the available government subsidies.

4.2 The need for reform of aged care was acknowledged. The Royal Australian College of General Practitioners (RACGP) noted that the third intergenerational report projects that over the next 40 years the number of Australians 85 years and over will more than quadruple from around 400,000 in 2010 to 1.8 million by 2050. The RACGP went on to comment that this will create an 'unprecedented demand' for the full range of aged care services and emphasised the need to increase funding for the sector.[1]

4.3 Aged and Community Services Australia (ACSA) raised the question of the timing of the health reforms in relation to aged care given that the Productivity Commission's inquiry into aged care and its interface with other social policy areas is currently ongoing. It continued:

> The fact that reform of other parts of the overall health and aged care system is proceeding ahead of this specific aged care Inquiry raises the risk that elements of the new health system will be put in place before the necessary linkages with aged care are fully considered. The fact that the aged care industry, aged care professionals and aged care consumers are not represented in any of the government structures and processes set up to progress the health reform agenda compounds this risk. Aged care needs a seat at the health reform table at more than just government level.[2]

Zero real interest loans and funding

4.4 Whilst supporting the extension of the Zero Real Interest Loans Scheme (ZRILs), Catholic Health Australia (CHA) raised concerns that it was targeted to selected regions and is 'only a partial response to the inadequacy of the current capital funding arrangements to sustain the expansion and renewal of residential services, especially the high care services that will be needed as the population ages'.[3]

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1 Royal Australian College of General Practitioners, *Submission 15*, pp 1–2.

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

3 Catholic Health Australia, *Submission 3*, pp 12–13.

4.5 CHA also raised the problem of access to general practitioner services in aged care facilities. CHA provided the findings of a GP Access Survey concerned with the availability of medical care in residential aged care settings. The survey, conducted across 6,364 residential aged care beds, found that 15 per cent of aged care homes report a shortage of GPs that results in compromised patient care; and 57 per cent of aged care homes reported admitting aged care residents to hospitals because of problems in accessing GPs.[4]

4.6 The ACSA stated that it remained to be seen whether the changes in the terms of the ZRILs will make any material difference to their ability to support the construction of 2,500 new beds.[5] ACSA went on to comment:

> The ZRILs are capped at $120,000, well below the cost of construction of new aged care homes ($180,000 upwards) meaning that other financing is likely to still be required. The ZRILS, and other loans, also do need to be repaid which means that a return on the capital investment is still required which is not possible under the current arrangements for funding accommodation in high level residential care.[6]

4.7 The Australian Medical Association (AMA) argued that the interest free loans needed to be supported by proper ongoing funding to ensure that new beds were actually constructed and maintained into the future. It continued:

> The AMA is concerned that without expanded ongoing investment, new aged care beds may not eventuate, and therefore not free up beds in public hospitals.[7]

4.8 Similarly, the ACSA commented that the aged care industry was 'sceptical' about the ability of the zero real interest loans to make more than a marginal difference to the viability of new aged care construction and held that pending the Productivity Commission inquiry's findings, 'the slow down in construction of the new capacity we need to meet the needs of an ageing population will continue'.[8]

4.9 Citing 2009 Access Economics research, CHA noted that revenue streams based on current accommodation payments for residential high care ($26.88 per bed day), construction of a new residential high care home would not proceed even with a construction cost per bed as low as $138,000 as the present value of revenue is less than the estimates of all the costs, making the internal rate of return less than the weighted cost of capital.[9] CHA noted that based on an average construction cost of $187,000 per unit to build an aged care home to contemporary standards, the required

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

5 The terms of the loans were increased from 12 to 22 years.

6 Aged and Community Services Australia, *Submission 17*, p. 3.

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

8 Aged and Community Services Australia, *Submission 17*, p. 3.

9 Catholic Health Australia, *Submission 3*, p. 13.

accommodation payment per day was estimated by Access Economics at $40.32 per bed day. CHA went on to note:

> A consequence of this situation has been under allocation of residential high care places in recent Aged Care Approval Rounds, and the handing back of allocated places (bed licences). Those developments that have proceeded have relied on the cross subsidy of low care and Extra Service bonds, and in some cases entry contributions from retirement village units.
>
> As a reflection of this dependency on bonds, the median bond held increased by 29% in 2008-09 to $200,000, and Extra service places grew by 36% in 2008-09.[10]

4.10 CHA held the view that a slow down in building activity will result from the long lead times involved with new service development and renewal. Such a slow down will result in a shortage of supply of suitable residential services in the medium term which will be difficult to reverse quickly.[11]

4.11 CHA also highlighted that extension of the Zero Real Interest Scheme continues the 'complex regime for capital funding, including as it does a mix of accommodation supplements, capital grants and zero real interest loans'. CHA questioned the extent to which fair and equitable treatment of providers is achieved by such complex arrangements and stated:

> In summary, the extension of this highly targeted Scheme for two years does not address the long term sustainability of capital funding arrangements for the sector overall.[12]

Long stay older patients and funding

4.12 CHA raised concerns that the long stay older patient (LSOP) places will be allocated at the 'partial expense' of the expansion of residential and community care places. CHA noted that it was not clear that the number of older people 'inappropriately accommodated in public hospitals will decline while the provision cap of 113 places per 1,000 people aged 70 and over remains in place, unless waiting lists in the community increase'.[13]

4.13 Highlighting that up to 40 per cent of residents of aged care facilities are malnourished, the Dietitians Association of Australia (DAA) noted that it was not clear whether the funding will only cover the basic costs of care or full services, including dietetic services. The DAA noted that while incentives for GPs will provide greater service to residential aged care, it stated that there is not adequate support for

10 Catholic Health Australia, *Submission 3*, p. 13.

11 Catholic Health Australia, *Submission 3*, p. 13.

12 Catholic Health Australia, *Submission 3*, p. 13.

13 Catholic Health Australia, *Submission 3*, p. 14.

the 'rest of the multidisciplinary team'.[14] The AMA also commented that more could be done to create 'more flexibility in how medical care for aged care residents is provided' and to achieve sustainable access to multidisciplinary medical and other health care and to reduce red tape.[15]

4.14 The ACSA argued that it was inappropriate, uneconomical and may be unsafe for older people to remain in hospital after their treatment had concluded and noted that for them to be appropriately cared for in the community, additional capacity in aged care was required which in turn required solutions to the 'crisis in capital raising'.[16] It noted moreover that:

> Under the new arrangements the Australian Government is paying 60% of hospital costs (rather than 0%) and, under this measure, is only offsetting the cost of the 2,000 beds by the amount of the aged care subsidy (average $96 per day on the figures above) leaving it with an incentive to find a more appropriate and cheaper placement in the community. It is imperative however that this subsidy is not looked on as a long term solution.
>
> In the short term the allocation of places to hospitals may obscure the fact that they are not in demand by aged care providers.[17]

4.15 CHA and other stakeholders expressed the view that access to aged care and subsidies should become an entitlement based on assessed care needs and capacity to pay, providing eligible people and their families a choice of care settings and provider.[18]

Commonwealth responsibility for a national aged care system

4.16 Professor Penington noted that there was 'no explicit plan' in relation to the Commonwealth assuming responsibility for aged care with COAG discussions set for 2011. He continued:

> With an ageing population and the prospect of large numbers of aged people in need of skilled assistance to sustain independent lives for as long as possible, constructive and innovative planning should be underway.[19]

4.17 However, whilst supportive of the Commonwealth's commitment to undertake full responsibility for aged care, the AMA was cautious in its approach to the investment put into aged care under the reform package arguing that, given the level of funding on offer for new places, it is 'unclear whether it will lead to an expansion of

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

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

16 Aged and Community Services Australia, *Submission 17*, p. 3.

17 Aged and Community Services Australia, *Submission 17*, p. 4.

18 Catholic Health Australia, *Submission 3*, p. 14.

19 Professor D Penington, *Submission 7*, p. 8.

services in reality, or an improvement in quality'.[20] The RACGP also highlighted that the current funding levels are inadequate and that what was still required included consolidation of Commonwealth community care programs to provide flexible funding for prevention and treatment of chronic and complex disease, greater remuneration for aged care workers (including GPs) to enable greater retention of health professionals in the sector, and increased technology and infrastructure funding to enable health care providers to take advantage of the e-health revolution.[21]

4.18 The ACSA raised concerns about the split in terms of responsibility for Commonwealth-state HACC program clients in which the aged care component will go to the Commonwealth and services for younger people (those below 65 years) becoming the responsibility of the states and territories. Of this it noted that whilst financial responsibility for packaged community care is to be split, the regulation of such services will remain with the Commonwealth.[22] Its position was that whilst on balance it supported the move to full Commonwealth responsibility for aged care:

> ACSA believes that the reforms and improvements needed in community care are made easier, though not guaranteed, by having a single level of government with unequivocal responsibility.[23]

4.19 The ACSA concluded that the financial measures in the reforms do 'nothing to address the immediate issues facing the delivery of aged care services, the declining value of care subsidies relative to costs and the lack of adequate access to capital' and noted:

> This means that the decline in the amount of community care available will continue as will the inability of aged care providers to pay higher wages to staff and compete with hospitals in the same labour market.[24]

4.20 The ACSA also commented that there was no representation of the aged care industry in any structures under the reforms.

Conclusion

4.21 The provision of care for Australia's ageing population poses significant challenges. The Government's proposed reforms do not address those challenges and those that were also identified by the Henry Review. They have been formulated before the Productivity Commission has completed its inquiry. The Productivity Commission is not due to report until April 2011.

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

21 Royal Australian College of General Practitioners, *Submission 15*, p. 2.

22 Aged and Community Services Australia, *Submission 17*, p. 4.

23 Aged and Community Services Australia, *Submission 17*, p. 4.

24 Aged and Community Services Australia, *Submission 17*, p. 4.

4.22 The decision by Victoria to retain control of the Home and Community Care (HACC) program will provide additional challenges as the Commonwealth assumes 100 per cent responsibility for aged care policy and funding.

4.23 In the meantime, the aged care sector is still under funded and lacking in certainty about capital funding to ensure that new beds are actually constructed and maintained. The complex funding arrangements remain.

4.24 It is doubtful that the measures to address the issue of long stay older patients will in fact see older people move out of public hospitals. To do so, there needs to be beds for them to go to and more importantly, staff to look after them.

4.25 Given that the Government is to redirect $276.4 million funding over three years from high-care residential aged care beds to the states and territories to provide 'similar levels of care' for LSOP in public hospitals, this seems unlikely any time soon.[25]

4.26 The future of aged care in Australia will continue to be uncertain until and after the Productivity Commission inquiry on aged care in April 2011.

25 Australian Government, *Budget Paper No. 2, 2010–11*, p. 223.

Chapter 5

Mental health

5.1 Many submitters voiced great disappointment with the COAG proposals and funding agreements in relation to mental health in terms of the level of funding, a lack of reform to mental health services, as well as a lack of integration of mental health in the planning and reform of the whole health system.[1]

Lack of funding

5.2 Of most concern was that the funding for mental health services does not reflect the burden of disease. The Royal Australian & New Zealand College of Psychiatrists (RANZCP) noted that one in five Australians experience a mental illness in any one year, but pointed to the poor level of funding:

> Current funding for mental health is inadequate. Funding for mental health should be reflective of the burden of the disease attributable to mental health. At least 14% of all health care funding should be directed towards mental health are, rather than the inadequate 6% it currently receives.[2]

5.3 Professor Patrick McGorry noted that whilst there were some positives for Australians with mental ill-health in that the 'agreement establishes a policy direction that emphasises the importance of providing young people with increased access to models of care', there were also negatives and uncertainties.[3] He continued:

> The principal negatives for Australians with mental ill-health are that the agreement exacerbates rather than addresses the structural under funding of mental health services and does little to advance the "historic reshaping of mental health services" that has been promised by the Prime Minister and that is urgently required.[4]

5.4 The lack of adequate funding was seen by the Mental Health Council of Australia (MHCA) as being particularly inexcusable given the funding of the reforms through a new tobacco excise:

> With 42% of all cigarettes sold in Australia being smoked by people with mental illness, the fact that the COAG health agreement is to be funded by

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1 See for example, Catholic Health Australia, *Submission 3*, p. 11; Professor D Penington, *Submission 7*, p. 9; Professor P McGorry, *Submission 8*, p. 1; Mental Health Council of Australia, *Submission 21*, p. 1; Australian Medical Association, *Submission 10*, p. 11; Royal Australian & New Zealand College of Psychiatrists, *Submission 12*, p. 2; Australian College of Mental Health Nurses, *Submission 23*, p. 1.

2 Royal Australian & New Zealand College of Psychiatrists, *Submission 12*, p. 1.

3 Professor P McGorry, *Submission 8*, p. 1.

4 Professor P McGorry, *Submission 8*, p. 1.

> the new excise on tobacco suggests that the primary role of mental health consumers is to underwrite improvements in systems that do not meet their needs.[5]

5.5 The funding of mental health was the critical issue for many other submitters. It was acknowledged that the Commonwealth's mental health package of $175.8 million includes $25.5 million over four years for new Early Psychosis Prevention and Intervention Centres (EPPIC) and $78.8 million over four years to establish up to 30 new *Headspace* sites reaching an additional 20,000 young people a year.[6] However, the MHCA submitted that the budgetary measures do 'little to address the crisis in the mental health sector in Australia' and are not a reflection of the outcomes of the consultation process undertaken prior to the COAG agreement.[7] The MHCA concluded these initiatives 'constitute vague in-principle support and incremental increases in just a few areas of urgent unmet need'.[8]

5.6 There was also concern that much of this funding was simply redirected or re-badged funding, rather than representing new resources directed at mental health. The Australian College of Mental Health Nurses (ACMHN), for example, argued that the mental health funding component included $31.4 million in new funding and $65.4 million in restored or redistributed funding.[9] Mr David Crosbie, of the MHCA also noted that the Commonwealth is providing more funding for mental health nurses but funding had been taken away from mental health nurses in the last budget.[10]

5.7 Professor John Mendoza also commented on the level of new funding:

> In mental health, the COAG package provides just $115m new funds over four years. There is a return of some of the previously reduced funding for mental health nurses (just $13m) and a further $57m of redirected funds from the Better Access program to tally up to the headline figure of $174m.[11]

5.8 The resignation of Professor John Mendoza was reported in the press on 20 June 2010. In a front page article entitled *Rudd Adviser Quits*, the Chairman of the National Advisory Council on Mental Health tendered his resignation in a letter to Minister Roxon last Friday (18 June). 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.

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5 Mental Health Council of Australia, *Submission 21*, p. 10.

6 Australian Government, *Budget Paper No. 2, 2010–11*, pp 234–235.

7 Mental Health Council of Australia, *Submission 21*, p. 1.

8 Mental Health Council of Australia, *Submission 21*, p. 2.

9 Australian College of Mental Health Nurses, *Submission 23*, p. 1.

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

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

> "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."[12]

5.9 Professor Mendoza's letter of resignation dated 18 June 2010, and effective immediately, includes this scathing assessment of the Rudd Government's efforts:

> Two years ago when we first met to develop the work plan for the Council you requested we develop a vision for mental health, a framework for accountability, proposals to improve the Commonwealth's current mental health investments and specific proposals for new investments based on evidence and (with emphasis) consumer and carer views. The Council has also responded to the requests for advice on the revised National Mental Health Policy, the 4th National Mental Health Plan, the revised National Mental Health Service Standards, the Better Access Program and the ATAPS program. All those requests were met.
>
> However, it is now abundantly clear that there is no vision or commitment from the Rudd Government to mental health. While significant improvements have been made in disability employment policy and to a lesser extent in housing and community services, there is no evidence of a change in policy or investment in mental health. 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.[13]

5.10 The RANZCP argued that over five years, the additional funding allocated to mental health amounts to $120 million compared to $7.3 billion for health in general. The RANZCP concluded that:

> Quality and integrated mental health services cannot be achieved through such a piecemeal approach to funding. These funding differentials will only serve to widen the gap further between mental health and other health services.[14]

5.11 This concern was shared by Professor Patrick McGorry who argued that $57 million of the $58.5 million flexible care packages is pre-existing funding and that $47.5 million of the $78.8 million in *Headspace* funding represents a continuation of the existing level of funding for *Headspace*. He argued that, on this basis, the allocation to mental health care represented a widening gap between mental health care and physical health care funding.[15] Professor McGorry continued:

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12 'Prime Minister Rudd's top mental health advisor John Mendoza quits', *The Sun Herald*, 20 June 2010, p. 1. http://www.heraldsun.com.au/news/breaking-news/prime-minister-kevin-rudds-top-mental-health-adviser-john-mendoza-quits/story-e6frf7jx-1225881829753

13 http://www.theage.com.au/pdf/resignation.pdf

14 The Royal Australian & New Zealand College of Psychiatrists, *Submission 12*, p. 2.

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

> The 2% of additional health funding allocated to mental health under this agreement is alarmingly small. It is one fifth of the proportion of health funding that mental health currently receives (6%) and about one tenth of the proportion of health spend recommended by the 2006 Senate Select Committee on Mental Health (up to 12%). It is less than a tenth of the share of Australia's health burden attributable to mental ill-health (13%). Such minimal growth is simply nowhere near enough to achieve any meaningful reform and better outcomes in mental health care.[16]

Unmet need for mental health services

5.12 Witnesses provided the committee with an overview of the level of unmet need for mental health services. Professor McGorry commented that there is a hidden waiting list in mental health of several million Australians including 750,000 young Australians. Lack of services for people with mental illness leads to more unnecessary and premature deaths and unnecessary disability.[17]

5.13 Mr Crosbie, MHCAH, illustrated the level of unmet need through the experience of those presenting with a mental health crisis at hospital emergency departments:

> Of the 76,000 presentations in 2006 in New South Wales emergency departments, 21,000 gained admission and 55,000 did not.[18]

5.14 Emergency departments are a first point of contact for persons seeking after hours care and those seeking assistance for the first time. However, 63 per cent were not admitted or provided with referral to another hospital. The MHRC quoted a 21 April 2010 newspaper report in *The Australian* to highlight the state that many people with mental illness would be in when they reached a hospital emergency department:

> For three days, Vittoria Tonin took a cocktail of drugs she expected would kill her, then wen it did not, she presented herself to the emergency department of the Royal Melbourne Hospital asking for help. She was 17 and in the final year of school. Although she had "some quite developed suicidal plans", the psychiatrist who saw her only offered her a late school pass.[19]

5.15 The MHCA noted that two-thirds of people with mental illness report that they didn't receive mental health care in 2006–07 whilst one in four people who made a suicide attempt did not access services for mental health problems in the previous twelve months.[20] It also highlighted the need for recovery support systems for

16 Professor P McGorry, *Submission 8*, p. 3.

17 Professor P McGorry, *Committee Hansard*, 8.6.10, p. 17.

18 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 99.

19 Mental Health Council of Australia, *Submission 21*, p. 4.

20 Mental Health Council of Australia, *Submission 21*, p. 4.

consumers discharged from hospital without adequate assistance including that of accommodation, employment options and other support. It argued for a more integrated model for mental health services, which:

> …acknowledges the whole of life needs of consumers and which effectively links treatment to ongoing recovery outside the hospital based acute setting, would improve treatment effectiveness and long term health outcomes.[21]

5.16 The RANZCP argued that there was an 'inherent unmet need' within the population that must be considered which was:

> …approximately 60% of those with mental disorders receive no specific mental health care. Concurrent to this projections suggest that mental health related disease burden will grow markedly as a proportion of overall disease burden, and community expectation of mental health care is increasing as specific campaigns raise awareness and expectation of treatment.
>
> Substantial additional investment in the prevention, diagnosis and treatment of mental illness will achieve both health benefits for individuals and families affected by mental illness in the short and longer term, but also bring broader community benefits such as increased productivity and workforce participation.[22]

5.17 The unmet need for mental health services is not restricted to only one part of the health care system with the AMA noting that:

> There is significant unmet need in the mental health system across the service spectrum, for prevention and early intervention, to sub-acute and acute care and specialist follow-up in both community and hospital settings.[23]

Community based services

5.18 Many submitters argued that the lack of community services is the major issue underlying unmet need for mental health services. Mr Crosbie, for example, stated that over the last 15 years, the number of community treatment beds halved, not withstanding the development of the National Mental Health Strategy.[24] The level of community based residential care for people with mental illness ranges from two beds per 100,000 in two states to 24 in another.[25] Mr Crosbie went on to comment:

> We need the community programs in place that we have really run down, if anything, since we closed all the institutions. We had 30,000 acute beds for

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21 Mental Health Council of Australia, *Submission 21*, p. 6.

22 Royal Australian & New Zealand College of Psychiatrists, *Submission 12*, p. 2.

23 Australian Medical Association, *Submission 10*, p. 11.

24 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 99.

25 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 101.

> eight million people in the sixties. Many of them were beds that we would never want to recreate, of course. We are down to 8,000 acute beds for double that population and we have halved the number of community beds. If I am a frontline service provider, a GP or anyone, who do I send someone to if they present, are starting to lose touch with reality and need some time out, maybe some medication and maybe some containment? What are the options at a community level? I go to countries like New Zealand and they have community run options. They do not have to go to a hospital.[26]

5.19 The MHRC's submission highlighted the ramifications for the health system as a whole when community services are not available:

> It is the case that many people with mental illness have little access to appropriate mental and other support in their local community and increasingly become unwell. This results in a vicious cycle that leads them back to the need for acute hospital based care, which could have been averted with adequate access to treatment options and community supports.
>
> Lack of strategic alternatives for many mental health consumers to adequately manage their illness in the community means that hospital emergency departments are a significant first point of contact in the mental health system.[27]

5.20 Mr Crosbie concluded:

> Everyone agrees, from the Prime Minister's statements to some of the senators sitting around this table, about the need for a greater investment at a community level, and yet I do not see that investment.[28]

5.21 SARRAH emphasised that people with chronic and severe mental health needs would be better cared for in the community if funding for community based mental health services were channelled through the PHCOs arguing that:

> To achieve better health outcomes for those with mental health problems, reforms must empower local structures in rural and remote communities to use funds flexibly and make decisions about the most appropriate packages of care.[29]

5.22 Concerns were raised regarding the $58.5 million funding directed at individual care packages which are to support up to 25,000 people. According to the Minister for Health and Ageing, the individual care packages will support clinical and

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26 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 105.

27 Mental Health Council of Australia, *Submission 21*, p. 4.

28 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 99.

29 Services for Australian Rural and Remote Allied Health, *Submission 6*, p. 5.

non-clinical care for up to 25,000 people with severe mental illness living in the community.[30] Mr Sebastian Rosenberg, for example, stated:

> The package also offered $57 million to develop tailored packages of care for 25,000 Australians with severe mental illness. Leaving aside that this amounts to $2280 per person, the exact nature of what model of care this expenditure seeks to advance eludes me.[31]

Funding for mental health services for young people

5.23 The Commonwealth has provided additional funding for *Headspace* and EPPIC. Professor McGorry stated that this was 'significant and positive in direction, but timid in scope and scale'.[32] He commented on the limited impact of the Commonwealth's proposals:

> The investment that has been announced will probably reduce by about three to four per cent the number of young Australians who are currently unable to get access to mental health care, and that is about 750,000 young Australians. So we will make some inroads, but the model that we proposed to the government earlier this year would have made a much bigger impact. Our target was to reduce the waiting list of 750,000 by about 200,000 to 250,000. Our goal was to make a much more serious inroad into that waiting list because people's lives are at stake here—young people's lives through premature suicide and death, their careers, their vocational opportunities and their families. The burden on their families is extreme…The frustrating thing is it is all preventable if we scale up these sorts of models more rapidly.[33]

5.24 Professor McGorry raised concerns regarding the practicability of the EPPIC investment model given that the 'allocated funding of $6.35m p.a. is significantly less than the cost of even one EPPIC centre (depending on scale these centres would cost between $10-20m p.a. to run)'.[34] Professor McGorry went on to comment:

> Therefore, even with co-investment by State Governments there remain significant implementation challenges to be overcome to provide young Australians with psychosis access to the most evidence based care.[35]

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30 The Hon Nicola Roxon MP, Minister for Health and Ageing, *Improving the Nation's Mental Health System*, Media Release, 20 April 2010, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/B1FD5F2BFF934FD1CA25770C0001C666/$File/nr075.pdf (accessed 21.5.10); Australian Government, *Budget Paper No. 2, 2010–11*, p. 235.

31 Sebastian Rosenberg, 'Waiting for Ruddo – mental health misses out at COAG', *Crikey*, http://www.crikey.com.au/2010/04/21/waiting-for-ruddo-mental-health-misses-out-at-coag/ (accessed 21.5.10).

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

33 Professor P McGorry, *Committee Hansard*, 8.6.10, p. 14.

34 Professor P McGorry, *Submission 8*, p. 3.

35 Professor P McGorry, *Submission 8*, p. 3.

5.25 Professor McGorry argued that the recent allocation for *Headspace* and EPPIC should be increased to $200 million a year.[36] He noted that this level of funding would increase capacity to make 'sustainable inroads into a huge hidden waiting list of young Australians currently denied mental health care'.[37] Professor McGorry highlighted that the new youth mental health funding (for *Headspace* and EPPIC) translates as $13.9 million per annum over new funding to provide care to an additional 23,500 people each year. He went on to state:

> This represents just 3% of the 750,000 young Australians who experience mental ill-health each year without accessing appropriate supports.[38]

5.26 Professor McGorry also noted that:

> EPPIC is demonstrably the most evidenced based model in the spectrum of mental health care and highly cost-effective. Though it is an internationally acclaimed Australian innovation that has been implemented in hundreds of centres across the world over the past 15 years, it has not yet been made available to the Australian population, except in heavily diluted fashion in Victoria.[39]

5.27 The MHCA held a similar view arguing that the 'welcome endorsement for proven youth mental health models is not matched by appropriate funding levels'.[40] It continued that there were good practice models that informed the recommendations of the 2006 Senate Select Committee inquiry into mental health services and the report of the NHHRC. It was also noted that:

> What is urgently needed now is serious consideration of why such services are not the norm in Australia's mental health system today and the implementation changes to the funding system that support this status quo.[41]

5.28 The concern that the initiative would only reach an estimated three per cent of young people with mental ill health was shared by the Mental Health Council of Australia.[42]

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36 Professor P McGorry, *Submission 8*, pp 1–2.

37 Professor P McGorry, *Submission 8*, p. 1.

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

39 Professor P McGorry, *Submission 8*, p. 1.

40 Mental Health Council of Australia, *Submission 21*, p. 2.

41 Mental Health Council of Australia, *Submission 21*, p. 3.

42 Mental Health Council of Australia, *Submission 21*, p. 2.

Need for further reform

5.29 Witnesses commented on significant underlying problems within the mental health system and stated that the Commonwealth's proposals do not address these problems.

5.30 Professor Patrick McGorry argued that mental health has been 'largely neglected' and that there was a 'mismatch between the urgency to act, scale of the need and power of Government rhetoric on the one hand and the timidity of action on the other'.[43] The MHCA similarly commented:

> …despite the rhetoric, state, territory and Australian governments do not seem to be committed to providing appropriate mental health services for consumers and carers or the Australian community.[44]

5.31 The MHCA also stated that 'the disconnect between the policy documents, the words, the plans and people's experiences is huge'.[45]

5.32 The MHCA argued strongly that since the release of the National Health and Hospitals Reform Commission final report in July 2009 and development of the National Health and Hospital Network, the focus of the Government has been on the hospital sector with 'only limited changes in the form of new funding initiatives to the mental health sector'.[46] The MHCA continued that:

> These announcements are not the strategic approach to reform that is needed in the sector. They do little to address the cycle in which mental health funding is used to support the increasing need for acute services in the hospital sector and little to address the urgent areas of unmet need in mental health, particularly in the community sector. If use of mental health funding in this way continues to remain a priority for state, area, local health services and hospitals, the access to mental health services, community support and early interventions that are so desperately needed will continue to remain elusive.[47]

5.33 Professor Patrick McGorry also commented on the focus on the hospital system, in particular, the increase in funding to decrease hospital waiting lists by a relatively small amount while the 'hidden' waiting list in mental health is much more serious. Professor McGorry stated:

> I just think it is logically bizarre that we see billions of dollars invested in reducing waiting lists by this much in the acute hospital system while we

43 Professor P McGorry, *Submission 8,* p. 4.

44 Mental Health Council of Australia, *Submission 21*, p. 10.

45 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 97.

46 Mental Health Council of Australia, *Submission 21*, p. 1.

47 Mental Health Council of Australia, *Submission 21*, p. 2.

> have got hundreds of thousands and even millions of Australians whose lives are at risk because of that other waiting list being totally neglected.[48]

5.34 Professor McGorry also questioned why this 'critically underperforming area of Australian healthcare has been largely neglected – with only confusing and unconvincing reasons offered to date'. He also stated that:

> It also remains unclear as to whether the Government has a plan to address this neglect. The current 4th National Mental Health Plan is manifestly inadequate and lacks vision, priorities and any evaluative framework of goals, targets and indicators or mechanism for accountability.[49]

5.35 Professor McGorry maintained that a new mental health investment program was needed which has an 'explicit overarching goal of ensuring Australia's mental health system is progressively scaled up to meet the same standards of quality and accessibility as our physical health system by 2020'.[50] He continued that:

> Until the Government announces a clear vision of mental health reform and a plan with specific targets to achieve it, and a serious growth strategy, confidence will continue to drain away from the mental health sector.[51]

5.36 Professor McGorry also argued that that health reform without mental health reform is 'both unfair and unlikely to succeed'. Professor McGorry stated:

> Better mental health means that we are more likely to enjoy better physical health. When we do become physically ill our stays in hospital are much shorter if our mental health is better. On top of that, these physical health benefits are further enhanced with better personal and social outcomes such as better career and educational success and reduced incidence of unplanned pregnancies, homelessness, violence and stress on families. It is actually a no-brainer that we need to invest in both physical and mental health care.
>
> However, most Australian communities are provided with an outdated model of health care that seeks to heal bodies but neglects minds…Australians are two to three times more likely to access quality care for physical health as for mental health. In other words, there is a huge discrepancy that is unfair, produces worse health and social outcomes and, perhaps more importantly from the point of view of the government at the moment, it wastes precious resources. This neglect is terribly wasteful. We have very good cost effectiveness studies showing that money is saved by early investment is mental health care.[52]

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48 Professor P McGorry, *Committee Hansard*, 8.6.10, p. 17.

49 Professor P McGorry, *Submission 8*, p. 1.

50 Professor P McGorry, *Submission 8*, p. 1.

51 Professor P McGorry, *Submission 8*, p. 4.

52 Professor P McGorry. *Committee Hansard*, 8.6.10, p. 9.

5.37 Professor David Penington argued that the recommendations of the 2006 Senate Select Committee on Mental Health inquiry report in relation to mental health funding should be revisited.[53]

5.38 The Consumers Health Forum of Australia also raised concerns in relation to what it saw as a lack of integration of mental health as part of the reform package:

> CHF is concerned by the absence of significant new mental health funding in the 2010-11 Budget, and the lack of any detailed plans around mental health as part of the National Health and Hospitals Network. We argue that it is essential that mental health is included as a fundamental element of the National Health and Hospitals Network, so that mental health care and treatment are integrated with the models of health services delivery.[54]

5.39 Submitters raised a number of other issues in relation to mental health services. The MHCA noted for example, that there was a need for greater accountability mechanisms to drive mental health reform. The MHCA argued:

> There is little or no comprehensive national public reporting of significant areas of interest to mental health consumers and carers such as health outcomes or service quality indicators. This means that there is little urgency for change and no way of evaluating the outcomes of initiatives that are implemented.[55]

5.40 In evidence, Mr Crosbie commented further that there were no measures of people's mental illness in Australia and what happens to them. There is limited data on use of mental health services 'but we do not know whether [people with mental illness] got better, how beneficial those interactions were and the degree to which it actually meets needs'. Mr Crosbie concluded:

> …it is this public transparency and accountability about people's experience of mental illness, their attempts to access care and the quality of care they get that need to be accurately documented or at least reflected if we are going to get real reform.
>
> I must say the health minister has made some quite powerful statements about the need to better document and to be more transparent and we strongly support those statements, but we are yet to see that reflected in the kinds of processes that have led to this agreement so we have real concerns about the degree to which they are going to offer the benefit that they potentially offer because there is a lack of transparency and a lack of accountability.[56]

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53 Professor D Penington, *Submission 7*, p. 9.

54 Consumers Health Forum of Australia, *Submission 2*, p. 3.

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

56 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 98.

5.41 The Dietitians Association of Australia noted that as a high proportion of consumers with mental health conditions also have co-morbidities, some of which develop as a side effect of pharmaceutical intervention, there needs to be a 'concomitant allocation of funding for allied health services such as dieticians to prevent and treat obesity, diabetes, and cardiovascular disease'.[57]

5.42 The ACMHN raised concerns that the coordinated care packages under the Access to Allied Psychological Services (ATAPS) program were to be introduced at the expense of removing mental health Social Workers and Occupational Therapists from the Better Access initiative, noting moreover, that mental health nurses working under the ATAPS were 'well placed to provide coordinated care packages as well as mental health Social Workers and Occupational Therapists'.[58]

5.43 The RACGP welcomed the funding for adolescent and young adult mental health services but lamented the lack of recognition and support for the role that GPs play in the early detention and treatment of mental illness and of the need for coordination between GPs, allied health professionals and other community support services.[59] The RACGP argued that the Medicare Benefits Scheme needs to be appropriately structured to allow GPs to dedicate time required to assess and understand their patients' mental health needs, provide cognitive and/or pharmaceutical treatment, and that of ongoing monitoring of their patients' condition.[60]

Conclusion

5.44 The promised leadership on mental health by the Commonwealth has evaporated. What has emerged with the announced reforms is a small, incremental change to the system which will do very little to address inequity in access to services and decrease unmet need for mental health services.

5.45 The committee notes the comments by Professor Patrick McGorry who pointed to the excellent evidence-based programs which are available in this country that, if provided with adequate funding could have a tremendous, positive impact for those Australians with mental illness. In particular, expanded funding for the *Headspace* and EPPIC programs would see many more young people access services.

5.46 The committee also notes that there is overwhelming evidence that the benefits of providing increased access for young people far outweigh the additional cost to the health budget. The reduction of disability, the improvement in survival rates, the decrease in use of services and improved outcomes point to the high cost effectiveness of early intervention programs. Professor McGorry stated that the costs

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

58 Australian College of Mental Health Nurses, *Submission 23*, p. 1.

59 Royal Australian College of General Practitioners, *Submission 15*, p. 3.

60 Royal Australian College of General Practitioners, *Submission 15*, p. 3.

are three times as much over an eight-year period if a person goes through the normal late intervention system.[61]

5.47 The committee considers that the Commonwealth has not delivered on its promise of reform of mental health services. Indeed, Professor Mendoza's comments in his letter of resignation show that the Rudd Government has not only failed to deliver, but is also falsely claiming achievements of the Coalition Government as its own:

> It is now abundantly clear that there is no vision or commitment from the Rudd Government to mental health…
>
> 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.[62]

5.48 Rather than honesty and accountability from the Rudd Government, the empty rhetoric continues and inadequate levels of mental health services remain.

61 Professor P McGorry, *Committee Hansard*, 8.6.10, p. 12.

62 Mendoza Letter to Minister Roxon 18 June 2010, can be found at: http://www.theage.com.au/pdf/resignation.pdf

Chapter 6

Other matters

Workforce reforms

6.1 Reforms in relation to the medical workforce were considered largely inadequate and unable to address the central problems of attracting and retaining GPs in primary care and medical professionals in rural and remote areas. Concerns were raised about the nurses working in general practice initiative duplicating services and leading to financial losses for larger practices in rural communities.

Medical workforce

6.2 The Commonwealth is providing $487 million in funding over four years to create more training places for GPs and funds to pay 975 junior doctors to experience a year in general practice. However, this extra funding was not seen as being enough to address the medical workforce problems in primary care. Professor John Dwyer, for example, commented that only 13 per cent of senior medical students in Australia have the intention to train as a GP. He argued that more was needed to make primary care a career choice:

> Without making a career in primary care seem more attractive, these dollars are unlikely to have the desired effect. Our young doctors are trained to deliver in multi-disciplinary teams in hospitals and will only be attracted to a life in primary care when they believe that, in doing so, they will be appropriately remunerated and experience the job satisfaction associated with really helping their patients.[1]

6.3 The Australian Medical Association (AMA) also put to the committee that it was less confident that the states would match the Commonwealth's commitment to increase the number of training positions in public hospitals and that:

> Unless States lift their overall contribution, it is likely that a shortage of quality training positions will occur or that the overall quality of the training in public hospitals will diminish.
>
> In implementing the IGA, it is essential that States be held to account for delivering the required number of high quality training places.[2]

6.4 In relation to the funding for new GP training and pre-vocational places, the Rural Doctors Association of Australia (RDAA) stated that whilst it welcomed the funding, it took the view that this initiative was merely a first step and that the

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1 John Dwyer, 'Health plan needs a few dollars more', *Australian Financial Review*, 11 May 2010.

2 Australian Medical Association, *Submission 10*, p. 11.

introduction of 'realistic measures to actually entice these and other doctors to move to the bush once they have graduated' was the next step which had been 'largely ignored'.[3]

6.5 In relation to the extra locum support in the package, the RDAA commented that 'there is so little there…the bottom line is we need more workforce out there. Locums are not going to do the job. If we get the workforce out there we can then provide them with the locum support to have time off'.[4]

6.6 The RDAA expressed its disappointment that 'the most significant health reforms of recent times do not involve the much-needed Rural Rescue Package' proposed jointly by the RDAA and the AMA. The package is designed to entice more doctors to the bush and better support rural practices. The RDAA went on to remind the committee of the realities of medical practice in the bush:

> At least 1800 doctors are needed immediately in rural and remote Australia to ensure even basic medical coverage in the bush. The influx of overseas trained doctors is the only reason that medical workforce numbers in rural areas are not in complete free fall. Close to 50% of rural doctors are overseas trained and in many areas 100% of services are being provided by overseas trained doctors, well above the national average of 25%.[5]

Nursing workforce

6.7 Whilst increased funding for practice nurses for GPs was welcomed, the Royal District Nursing Service (RDNS) voiced concern that the proposal may in fact lead to duplication of services. The RDNS noted that the funding will be used to employ practice nurses to provide care outside the GP clinic. However, 'across Australia there are nurses and other health professionals employed through other programs who already provide care in settings such as the home – RDNS and our interstate counterparts are examples'. The RNDS continued:

> With new funding provided through Medicare there is a risk of duplication as GPs seek to set up systems and structures which duplicate those already in existence. Surely it would be more cost efficient to allow existing providers (even though they do not have a provider number) to be able to access this funding and provide this service).[6]

6.8 The ACMHN commented that the $523 million to support nurses in the area of general practice and aged care was 'woefully inadequate' for a profession with over 250,000 members.[7] It also noted its disappointment that the Mental Health Nurse

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3 Rural Doctors Association of Australia, *Submission 22*, p. 1.

4 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard*, 7.6.10, p. 67.

5 Rural Doctors Association of Australia, *Submission 22*, p. 2.

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

7 Australian College of Mental Health Nurses, *Submission 23*, p. 2.

Incentive Program's provision of $13 million only 'returns the program funding to around 35% of the original commitment' and that it requires additional investment to support the uptake of the program by mental health nurses, GPs and psychiatrists.[8]

6.9 Mr Steve Sant, RDAA, stated that there were significant concerns around the nurses working in general practice initiative (the Practice Nurse Incentive Program (PNIP)). Modelling undertaken by the RDAA indicated that practices in larger rural towns which have come together as a single practice for efficiency reasons would lose money under the initiative:

> These are practices that are larger practices in rural Australia, probably in centres of close to 20,000 or 30,000 people. They are large practices of more than five doctors, often as large as 20 or 30 doctors. Because of the caps on the way that program has been set up, and because those practices have very well utilised practice nurses and using the practice nurse items, they potentially could lose up to $100,000.[9]

6.10 The RDAA noted that whilst there was a guarantee against financial loss within the initiative, it was limited to three years. The RDAA concluded that the initiative would be 'unlikely to encourage those practices to continue to use nurses to the same extent in the longer term' and thereby, reduce access of their local community to care.[10] It has taken the matter up with the Government 'but we are yet to hear any real outcome'.

6.11 Mr Sant concluded:

> We have yet to see whether [the reforms] will have 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 really needed.[11]

6.12 In response to these concerns, Ms Huxtable of the Department of Health and Ageing stated that it was not the intention of the measure to 'go backwards in any way' and that rather, it was to provide a 'more sustainable foundation for practice nurses' whilst providing medical practices with flexibility in terms of 'how they can use practice nurses'.[12]

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8 Australian College of Mental Health Nurses, *Submission 23,* p. 2.

9 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard,* 7.6.10, p. 65.

10 Rural Doctors Association of Australia, *Submission 22,* p. 6.

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

12 Ms R Huxtable, Department of Health and Ageing, *Committee Hansard,* 7.6.10, p. 32.

Electronic health records

6.13 Concerns were raised by involved stakeholders regarding the funding of the proposed electronic health records system otherwise known as e-health. Issues including the security of the information that will be kept on the records, who will be able to access information and whether the records will become a means to achieve 'function creep' through the use of such information for other purposes have been raised.[13]

6.14 The National E-health Strategy prepared by Deloitte estimated that the development of a national system would cost around $1.5 billion over five years or $2.6 billion over ten years.[14] Questions have been raised, therefore, about what the pledged Commonwealth funding can achieve.

6.15 University of Sydney surgery professor Mohamed Khadra argued that with more than 100 different computer platforms used by doctors and other medical professionals, it was impossible for the budget allocation to cover the costs of integrating all those systems.[15]

6.16 SARRAH emphasised that access to electronic health records and other key strategies should not be limited to those 'soon-to-be Nationally Registered Professionals, as this would limit access to services critical to improved health outcomes and health reforms'.[16]

Health care in rural and remote areas

6.17 The RACGP noted that the NHHRC recommendation 65 for a patient travel and accommodation assistance scheme which takes account of out-of-pocket costs of patients and their families and facilitates timely treatment and care in the achievement of delivering health outcomes to remote and rural communities has not been realised. Of this it stated:

> The College believes that the Government should adopt the NHHRC's recommendation and introduce a nationally consistent patient travel scheme, which will provide much needed access to medical services for

13 Adam Cresswell, Experts warn over medical records plan, *The Australian*, 13 May 2010, http://www.theaustralian.com.au/in-depth/budget/experts-warn-over-medical-records-plan/story-e6frgd66-1225865740097 (accessed 10.6.10).

14 Deliotte, *National E-Health Strategy*, 30 September 2008, p.90, http://www.health.gov.au/internet/main/publishing.nsf/Content/604CF066BE48789DCA25751D000C15C7/$File/National%20eHealth%20Strategy%20final.pdf (accessed 25.5.10).

15 Fran Foo, Expert slams meagre e-health funding, *The Australian*, 12 May 2010, http://www.theaustralian.com.au/in-depth/budget/expert-slams-meagre-e-health-funding/story-e6frgd66-1225865353736 (accessed 10.6.10).

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

> patients in rural and remote communities, and contribute to the Government's Closing the Gap Campaign.[17]

Medicines associated with health care

6.18 The Society for Hospital Pharmacists of Australia (SHPA) emphasised that there was an 'absence of any consideration for the use of medicines associated with almost all health care' which implied that the 'continuation of the plethora of medicines funding systems looks set to continue'.[18] The SHPA stated:

> A plethora of arrangements now underpins hospital medicines funding, some of which include cost-shifting opportunities between government funders. Reforms should improve transparency and efficiency of care, as well as providing information about the safe and cost-effective use of medicines in all health care settings. This will strengthen future local and national evidence based decision making, including the anticipation of changes in the use of medicines and future funding needs.[19]

17 Royal Australian College of General Practitioners, *Submission 15*, p. 4.

18 The Society for Hospital Pharmacists of Australia, *Submission 9*, p. 3.

19 The Society for Hospital Pharmacists of Australia, *Submission 9*, p. 3.

Chapter 7

Conclusion

Labor's wasted opportunity for real health reform

7.1 During the lead-up to the April 2010 COAG meeting on health reform, the Prime Minister toured the length and breadth of the country, perched earnestly each day on the beds of the nation's patients commiserating with them over the multiple ills of the health system and most especially, the public hospital system. Mr Rudd was pictured in his white coat eagerly extending his hand of comfort and promising that he would take control of health care delivery, bringing 'an end to the blame game' between the Commonwealth and state governments and promising a 'federally funded, locally run' system.

7.2 Mr Rudd warned the Premiers to get out of the way of his health reform train. At the conclusion of April COAG meeting, the Prime Minister proclaimed the outcome as the greatest reform of the health system since Medicare, and the Premiers and Chief Ministers (except Mr Barnett from WA), newly enriched by Mr Rudd's various inducements to their coffers, were pleased to endorse that view.

7.3 However, as is clear from the many submissions and evidence at the hearing by health professionals who understand the system, there is a clear view that Mr Rudd has squandered a rare opportunity for true health reform. Indeed, the recent resignation of Professor Mendoza, Chair of the National Advisory Council on Mental Health, and the strident criticism of Professor Patrick McGorry regarding lack of focus on mental health in the package at the committee's hearing are only two of the examples of what has been described as a wasted opportunity for real reform.

7.4 In short, the outcome the Prime Minister negotiated is a policy and governance failure that will do nothing to 'end the blame game' between the Commonwealth and the states, while entrenching state control of the hospital system. This is a far cry from Mr Rudd’s 2007 election campaign promise of a 100 per cent takeover of the health system, when he promised that 'the buck will stop with me'.

7.5 After two and a half years of talk about reform, Mr Rudd announced the vastly less ambitious plan to simply reverse the current 40/60 per cent Commonwealth/State funding responsibility for hospital services to a 60/40 per cent split. Mr Rudd and Minister Roxon, insisted that the Commonwealth's 60 per cent 'dominant' share was the key and non-negotiable reform required to drive the reform plan, thus justifying the claw-back of 30 per cent of GST revenue.

7.6 The Australian public was invited by Mr Rudd to conclude that this would enable the Commonwealth to bypass incompetent and bloated state health bureaucracies to deliver the funding directly to the treating hospitals through the new Local Hospital Networks. However, the devil in this case is in the *lack of detail*. It was

very clear from the evidence to the inquiry that it is unclear precisely how the 60/40 split will 'end the blame game'.

No real reform and business as usual with the States and territories

7.7 It is clear that critical concessions were made to Victorian Premier Brumby in return for his agreement on the 30 per cent GST claw-back.

7.8 This focused on the establishment of separate health funding pools in each state and ensuring key governance elements remained with the states as well, including the selection of the Local Hospital Networks (LHNs). In short, in order to ensure a successful political outcome from his negotiations, at least with the Labor Premiers, Mr Rudd backed down on elements he had earlier described as critical to reform.

7.9 It is clear from the evidence and most particularly from the terms of the National Health and Hospitals Network Agreement (the 'Intergovernmental Agreement') that there has been no fundamental change in the roles and responsibilities of the Commonwealth and the states in health care delivery. It is unlikely that there will be any reduction in the size of the state and territory health care bureaucracies but there will be a new level of bureaucracy necessary to manage the new and complex funding arrangements between the Commonwealth and each of the individual states and territories.

7.10 One cannot but cynically think that perhaps the real intention was to leave the states in control of key aspects of the hospital system, so that the Federal Government can take the credit for any improvements in the system while continuing to attribute the blame for any failures to the states.

Specific concerns about the plan

7.11 Many concerns were raised about the plan. These included:

The involvement of local clinicians

7.12 Many submitters argued the need for local doctor representation on Local Hospital Networks and expressed concerns that the specific wording in the Intergovernmental agreement that clinical expertise will come from outside the local area, wherever practical which contradicts the promise of 'locally run'.

7.13 In short, there is a strong view that the doctors on the LHNs must come from the local communities served.

Governance and financing issues

7.14 Many submitters raised their concerns about the lack of detail regarding governance and accountability issues.

7.15 These concerns are compounded by the dumping of the central accountability and transparency mechanism of the National Funding Authority, which was inserted to ensure that the states and territories did not siphon off funds for other purposes or for added bureaucracy.

Activity-based funding and capping

7.16 Despite all the hype, it is clear in the Intergovernmental Agreement that the states and territories will decide not only the boundaries of each LHN but will also determine the budget for each LHN. States decide what services they will 'purchase' from each LHN under their agreement with the LHN.

7.17 This service agreement remains entirely a matter for the LHN (created by the state or territory) and the relevant state or territory government. Without any oversight it is not possible to guarantee that state governments may use these agreements to restrict rather than expand services in particular areas.

Recurrent and capital budget control: more opportunities for 'blame game'

7.18 Concerns about the 'blame game' continuing were succinctly summarised in this quote from the AMA submission:

> The AMA is concerned that the funding structure agreed to in the IGA will not end the blame game, but instead merely provide different opportunities to undermine and 'game' the system.[1]

7.19 Many of the details about recurrent and capital budget control are unclear. Specifically, while the Commonwealth will pay 60 per cent of the 'efficient cost' of hospital patient services, the states and territories will determine the level of services that each LHN will provide.

7.20 It remains unclear how the total budget available each year will be determined. Similarly, the Commonwealth will pay 60 per cent of capital expenditure but it appears the states will determine the total level of capital spending. On that basis, it remains unclear how the Commonwealth could prevent the states from setting the total recurrent and capital budget in any year to whatever level the states could afford at the 40 per cent contribution level with the Commonwealth consequently having to provide its 60 per cent share.

7.21 There are many references to the respective treasuries and treasurers providing advice on these issues, but concerns remain that the financial governance is wide open to disputed interpretations at each COAG meeting, so that the level of disputation may be worse than ever.

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

Bureaucracy

7.22 It is clear that there are several additional bureaucratic structures, both state and federal.

7.23 Whilst the stated intention is that the plan is that they be introduced with no increase in bureaucracy, concerns have been raised that this is not likely to be the case. Disappointment has been expressed about this given the original purpose was to reduce duplication and improve efficiency.

7.24 Other concerns have been raised. These include:

- how the new Independent Pricing Authority is meant to achieve the 'efficient price' of services given the absence of data that could be used for this purpose;
- doctors' opposition to any move away from fee-for-service funding; and
- the lack of involvement of private hospitals in the plan.

7.25 In conclusion, despite having over two and a half years of talk about health reform, the plan now being sought to be implemented was a massive political compromise from the Prime Minister cobbled together in the weeks preceding COAG.

7.26 Instead of achieving a 'federally funded, locally run' system, the Prime Minister has been comprehensively out-manoeuvred by the states which have ended up gaining substantial increases in funding without guarantees of improved patient access and outcomes. Australians had expectations that this plan would result in better run public hospitals. There is no confidence from the evidence in this inquiry that this will be delivered.

Senator Scott Ryan

Chair

Additional comments

Senator Scott Ryan

In recent years, as State Public Hospital systems have fallen further behind the standards expected of them, arguments in favour of greater centralisation of health policy and funding in Australia have become more prominent. These arguments have usually advocated the Commonwealth taking complete control of and responsibility for Australia's health sector.

This argument for national control reflects an assumption that central control of health would in some way deliver better outcomes. Yet little or no evidence to support this claim is offered.

The sentiment that "Canberra knows best" or "Canberra does best" also undervalues the tensions inherent in a federal arrangement that have served to develop and support Australia's complex health system, including those elements that are successful.

One of the core benefits of a federal approach in contrast to a uniform, single national approach is that of policy trial and comparison.

Varying management and funding regimes in operation across the states have allowed for different policy responses to the funding and resource pressures inevitable in public hospital systems, particularly one with low or no price signals at points of access.

The ability of state-managed hospital systems to trial various policy responses to these challenges are obvious from a cursory glance at our public hospital system.

The most successful of these has been in relation to the method of funding hospitals. Activity-based funding ('casemix') was introduced in a significant fashion in Victoria's hospital system by the Kennett Government in the mid 1990s. The rationale behind the introduction of casemix funding was to drive hospital behaviour by rewarding performance and efficiency.

The political opposition to this change at the time of its introduction should not be underestimated. Doctors, unions and, most notably, the then State Opposition Leader Mr John Brumby, consistently attacked the introduction of casemix funding, arguing it would reduce patient care. Only fifteen years later, it is argued that this model, first introduced in Victoria, would dramatically improve patient care if implemented across Australia.

With the significant opposition of vested interests to such reforms, it is highly doubtful that such a dramatic reform could or would have been implemented at a national level. There is no evidence to suggest that the ability to challenge vested or provider interests is greater from the distance of Canberra than our state capitals, problematic though the behaviour of the latter has been this past decade.

The Rudd Government's so-called health reform package, more accurately titled a hospital administrative and spending package, illustrates the problems of inertia in any large government-run system. As funding is dominated by the inertia of past practice, large institutions and the loudest voices, the opportunities for radical or substantial reform, particularly those that challenge provider interests, is diminished. This is exacerbated by moving from state-run systems that may vary across the country to a single, national approach.

As the Kennett casemix funding reforms have proven successful, the differences between the public hospitals in Victoria and other states have become more apparent. Although I hasten to add that most Victorians would be surprised and concerned to hear that the state of Victorian hospitals is apparently a benchmark for national reform, as Victorian hospitals do not meet the needs of the Victorian community.

Determining a single, national model for hospitals may well ensure that the next wave of reform is stifled. The more nationally-dominated and controlled our health system is, the less capacity for a single jurisdiction to undertake a reform program akin to that implemented by the Kennett Government in Victoria.

It should be noted that in health the most significant area of influence by vested interests in public hospitals relates to labour costs. The increase in labour costs has been a major factor in the dramatic increase in health spending over the past decade.

One of the great benefits of a federal approach and differing regimes is limiting the ability of capture by vested interests. In terms of public sector service provision this risk is magnified.

As the major element of recurrent health budgets, restraining growth in labour costs is a critical part of driving efficiency in our health system. In this regard, the states have particularly failed over the past decade as they have become further captured by public sector provider interests at the expense of the interests of consumers and taxpayers.

There is no evidence to suggest that this would in any way be addressed by a more centralised arrangement. Indeed, the removal of varying jurisdictions' responsibility for labour agreements would simply increase the risk of capture by provider interests as the number of responsible governments would be reduced from eight to one.

Furthermore, the balance of responsibilities that exist in our health system has served it well in two respects.

First, the inability of a single jurisdiction to impose its own preferred model of health policy has prevented a government imposing a policy that does not have some degree of consensus wider than the governing party. As many of the views in the health policy debate represent those of different providers, and the genuine consumer voice is rarely if ever heard, this limitation on the power of one government to act should not always be seen in a negative light.

Second, ongoing political pressure from elections in different jurisdictions has ensured a constant and ongoing accountability for health policy. Health is an issue at every state and federal election - this ongoing political pressure is removed if a single level of government has unilateral responsibility.

Senator Scott Ryan

Senator for Victoria

Government Senators' Dissenting Report

The need for reform

1.1 The Australian Health System is undergoing a major reform process after more than a decade of lost opportunities under the Howard government.

1.2 As the Department of Health and Ageing website reports:

> Health reform is designed to significantly improve and modernise Australia's health system. This will mean the largest change to our health, hospitals and aged care system since the introduction of Medicare.

1.3 The comprehensive package totalling $7.3 billion over five years to reform Australia's health and hospitals system, includes:

- Improving our hospitals;
- Better access to GP and primary health care services;
- Training more doctors, nurses and allied health professionals;
- Supporting aged care;
- Investing in prevention;
- Helping those with mental illness; and
- Modernising our health system.

1.4 The Australian Government is delivering fundamental health reform and significant additional investments which are fully funded over the forward estimates, wholly consistent with the fiscal strategy, and not adding to the budget deficit.

1.5 The National Health and Hospitals Network will ensure future generations of Australians enjoy affordable and universally accessible health care.

1.6 The Australian Government will become the dominant funder of hospital services and have full policy and funding responsibility for GP, primary health care and aged care.

1.7 The Australian Government will leverage its funding responsibility to deliver more coordination, control and accountability at a local level. This includes a new national performance framework to make the system more transparent and drive improvements to ensure all Australians can access high-quality, safe and efficiently run health care.

1.8 These reforms will deliver better health and hospital services by:

- Helping patients receive more seamless care across sectors of the health system;
- Improving the quality of care patients receive through performance standards and improved engagement of local clinicians; and
- Providing a secure funding base for health and hospitals into the future.

1.9 In total, the Government will provide $7.3 billion over five years to fund the new health reform initiatives. The initiatives will be introduced progressively from 1 July 2010.

1.10 There was a consensus that the Australian health system has been struggling to meet increasing demand for services with inadequate funding and outdated structures. Dr Andrew Pesce, President of the AMA, stated that 'there is no doubt that Australia needs health reform and it needs significant reform of its health care system'.[1] Ms Carol Bennett, Consumers Health Forum (CHF), also commented on the problems facing health care in Australia and noted that the system is 'under pressure and unresponsive to the needs of some people, particularly those with chronic health conditions'. The CHF stated 'substantial reform is what is needed if the system is to be responsive and sustainable into the future'.[2]

1.11 The problems facing the health care system are not something that has emerged in the last two years. Under the former Federal Coalition government's last health care agreement, state expenditure on health grew at a faster rate than the Commonwealth's – the Commonwealth was not meeting its responsibility and paying its fair share. In the 2003–04 Federal Budget the then Government, and Health Minister Tony Abbott, significantly reduced the budgeted funding across the forward estimates for the Australian Health Care Agreement. These actions perpetuated the 'blame game' leading to poor outcomes, inadequate funding, and less than optimal outcomes.

1.12 As a consequence of inheriting these systemic problems within the health care system, the Rudd Government established the National Health and Hospitals Reform Commission (NHHRC) to provide a long-term health reform plan for Australia. The Commission provided three reports to the Government following extensive and detailed consultations with stakeholders and users of the health care system from across Australia, and the examination of submissions received. The Commission provided the Government with 123 recommendations directed at restructuring and improving the health care system.

The National Health and Hospitals Network reforms

1.13 On 20 April 2010, the Prime Minister, Premiers and Chief Ministers of States and Territories, with the exception of Western Australia, reached an historic agreement at the Council of Australian Governments (COAG), on health and hospitals reform – the establishment of a National Health and Hospitals Network (NHHN).

1.14 This represents the most significant reform to Australia's health and hospitals system since the introduction of Medicare, and one of the largest reforms to service delivery in the history of the Federation. The full details of the Government's reform package are available on the internet at www.yourhealth.gov.au.

1.15 The Government states that the reforms will have three primary objectives:

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1 Dr A Pesce, Australian Medical Association, *Committee Hansard*, 7.6.10, p. 106.

2 Ms C Bennett, Consumers Health Forum, *Committee Hansard*, 8.6.10, p. 1.

- Reforming the fundamentals of our health and hospital system, including funding and governance, to provide a sustainable foundation for providing better services now and in the future.
- Changing the way health services are delivered, through better access to high quality integrated care designed around the needs of patients, and a greater focus on prevention, early intervention and the provision of care outside of hospitals.
- Providing better care and better access to services for patients right now, through increased investments to provide better hospitals, better infrastructure, and more doctors and nurses.[3]

1.16 The Government has included 94 of those recommendations of the NHHRC in the NHHN reform package. There are also further recommendations still under consideration including those pending the outcome of the Productivity Commission report on ageing. As the Chair of the NHHRC told the Committee, the Commissioners were supportive of the reform package:

> …it would be fair to say that we are all quite delighted that the vast majority of what we put forward—which represented, as I said, the thinking of thousands of people around Australia—was being acted upon. I think the investment that has been envisaged is a very significant investment and similar to what we hoped for.[4]

1.17 The AMA noted that structural reform of our health system is very difficult and 'one that governments have found easier to avoid rather than engage with'.[5] This Government has not avoided this difficult task; and the outcome will be that the health care system that is provided by this Government will be better prepared, with an increased capacity to treat patients safely, and to meet the demand of an ageing population and improving the capacity of all Australians to access the best care and best medical technology in a timely and appropriate way.

1.18 NHHN reforms are a very significant investment by this Government to improve an ailing health care system to the benefit of all Australians. Combined they represent an investment of $7.3 billion over five years. Ms Leanne Wells of the National Primary Health Care Partnership noted:

> …the $1.7 billion of new money for primary health care in the federal budget for initiatives in after hours and aged care, some small investments in mental health and in coordinated diabetes care, is a really good and fairly unprecedented investment in primary health care.[6]

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3 Dr A Pesce, Australian Medical Association, *Committee Hansard*, 7.6.10, p. 106.

4 Dr Christine Bennett, *Committee Hansard*, 8.6.10, p. 29.

5 Dr A Pesce, Australian Medical Association, *Committee Hansard*, 7.6.10, p. 108.

6 Ms L Wells, National Primary Health Care Partnership, *Committee Hansard*, 8.6.10, p. 61.

1.19 The NHHN reforms establish new funding arrangements that will see the Commonwealth as the dominant funder with the means and the motive to connect and integrate health and aged care service across every person's life span. The reforms strengthen primary health care and care in the community which will decrease the level of hospitalisations and embed prevention and early intervention into the health care system. As Dr Pesce of the AMA noted in his support for proposals which he saw as 'really significant steps forward', these 'would never have happened unless the Commonwealth had taken responsibility to adopt a national approach to health reform'.[7]

1.20 The NHHN reforms will provide a secure base for funding of vital health services – something that the former Coalition Government and the then Minister for Health Tony Abbott failed to provide. There will be much greater transparency on how health services perform, not only the public sector but also the private sector. For the first time, there will be a capacity to compare across the sectors. As Ms Halton, Secretary, Department of Health and Ageing, commented:

> This transparency, together with greater clinical engagement, will drive continuous improvement and create what the National Health and Hospitals Reform Commission called 'an agile and self-improving health system'.[8]

1.21 The AMA supported the changes to funding arrangements and the improvement to transparency and accountability so that where and how health dollars are spent can be identified, so that 'most funding will no longer pass through State governments in a way that will allow it to be "reduced" before it actually reaches hospitals'.[9]

1.22 Mr Bo Li of the Australian Health Care Reform Alliance also supported the shift in funding arrangements and stated that it 'is a good outcome for the health of Australians'.[10]

1.23 The reforms were welcomed by other organisations: the Australian General Practice Network (AGPN) for example, stated:

> We support the overarching principles of the National Health and Hospital Network Agreement, in particular the principles of a nationally unified and funded system that is locally controlled, delivered and accountable through hospital performance agreements and healthy communities' reports.[11]

1.24 The Consumers Health Forum welcomed the greater policy setting and performance measurement at the national level with Ms Carol Bennett commenting:

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7 Dr A Pesce, Australian Medical Association, *Committee Hansard*, 7.6.10, p. 112.

8 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 2.

9 Australian Medical Association, *Submission 10*, p. 2.

10 Mr Bo Li, Australian Health Care Reform Alliance, *Committee Hansard*, 8.6.10, p. 46.

11 Mr L Wells, Australian General Practice Network, *Committee Hansard*, 7.6.10, p. 87.

> It offers us an opportunity to get some national consistency in the way our health system operates, which is a bit different to the way it has been operating to date. We believe that it can work and that it can work for the benefit of the people who use the system, but we need to make sure that that happens and that this is not a lost opportunity.[12]

Funding and governance

1.25 The NHHN reforms will implement a health system that is funded federally and run locally. For the first time the Commonwealth Government will take the majority funding responsibility for the entire health system. As Ms Halton explained to the committee:

> This is a very significant structural change. It means that there will be one dominant funder with the means and motive—and I believe this is important—to connect and integrate health and aged care services for people right across the life span, to strengthen primary care and care in the community so that Australians do not have to find themselves unnecessarily in hospitals and, importantly, to embed prevention and early intervention into our health system.[13]

1.26 The Commonwealth will fund 60 per cent of the efficient price for all public hospital services, and 60 per cent of capital, research and training in our public hospitals. The Commonwealth will also take full funding and policy responsibility for GP and primary health care services, and for aged care services.

1.27 Importantly the Government will move to fund hospital services on the basis of activity based funding which the NHHRC recommended would create strong efficiencies in the health system. However the NHHN reforms include commitments to ensure the future of small rural hospitals – including using block funding where appropriate. The Commonwealth has also committed to moving over time to fund 100 per cent of the efficient price of primary health care equivalent outpatient services.

1.28 The management and governance of health services will be devolved more to a local level. The NHHN will introduce Local Hospital Networks to be responsible for the management of hospitals which will increase the flexibility for the hospitals to meet the needs of local communities. The reforms will also introduce primary health organisations called Medicare Locals to drive integration across local GP and primary health providers and increase the availability of services – particularly after hours. One stop shops will also be established across the country for aged care services.

1.29 In addition new, higher national standards and transparent reporting will provide Australians with more information than ever before about the national, state and local performance of the health system.

1.30 Coalition criticism of the Government's decision not to introduce the National Funding Authority, ignores the fact that the arrangements involving a joint State-Federal funding authority in each State and Territory will actually lead to greater

12 Ms C Bennett, Consumers Health Forum, *Committee Hansard,* 8.6.10, p. 5.

13 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 2.

transparency over funding arrangements as state hospital spending will be subject to the same transparent conditions.

1.31 In addition the Opposition Senators also wrongly and mischievously claim that there will not be local governance and management of hospitals. As the NHHN agreement makes clear, the day-to-day management of the system will clearly be a responsibility of the Local Hospital Network – and the Government has made very clear in its evidence that its preference is for the people on the Governing Councils to be the best people for the job, which will no doubt involve local clinicians, in many instances, serving on these councils.

Hospital investments

1.32 In addition to the above financial and governance reforms to the hospital system, the NHHN reforms also include specific investments in hospitals. These are:

- $1.62 billion for sub-acute care. From 2010-11, the number of sub-acute beds will ramp up to reach 1,316 additional beds in the public hospitals system by 2013-14. The funding for these beds could be directed to rehabilitation, step down, mental health and palliative care beds.
- $800 million for elective surgery. This includes $650 million in upfront and reward funding and $150 million in capital funding, to help ensure patients are seen within the clinically recommended time (fully implemented by December 2015), and to provide a guarantee that patients who are overdue for surgery will be able to receive the surgery in another public or private hospital rapidly.
- $750 million for emergency departments. $500 million will provide for the equivalent to an estimated 805,000 emergency department attendances in 2013-14 – these patients will be admitted, referred or discharged within the new four-hour target. This also includes $250 million in capital funding.
- $200 million in flexible funding which states can invest in emergency departments, elective surgery and/or sub-acute beds.

1.33 Committee witnesses such as Catholic Health Australia described the extra investments in hospitals as a "terrific outcome" given the social benefits:

> Why would we think that providing public elective surgery to patients within clinically recommended times is terrific? It is because we are seeking to ensure that all Australians, regardless of income level and regardless of their socioeconomic status, have equitable access to health care when they need it.[14]

Primary Health Care

1.34 The NHHN reforms deliver on landmark reforms to primary health care, drawing upon the work of the NHHRC and the Draft National Primary Health Care Strategy – both aiming to treat more people outside of hospital, ensuring a better

14 Mr M Laverty, Catholic Health Australia, *Committee Hansard,* 7.6.10, p. 55.

management of conditions such as chronic diseases. Evidence before the committee saw this as a key positive of the Government's reforms:

> …my overriding comment would be that the reforms are welcome. The Australian Health Care Reform Alliance has been a long-term advocate for change in the healthcare system and particularly very keen to see a focus shifting away from a very hospital centric system to a system that actually stops people needing to go to hospital at the rate that we go.[15]

1.35 The reforms include major investments in primary health care including:

- $449 million for coordinated services for people with diabetes;
- $355 million for 425 GP Practice upgrades and 23 new GP Super Clinics; and
- $417 million to establish a national GP after hours service and Medicare Locals.

1.36 The AGPN recognised the benefit in the package for primary health care as the reforms will build on the services that the divisions of general practices provide to general practice as well as the initiatives for e-health, practice nurses and support of GP access to allied health services. In particular they have recognised the benefit of voluntary enrolment as a method for providing more coordinated service for diabetes patients and would like to see the concept extended further:

> We welcome enrolment, because we have advocated for voluntary enrolment for some time. We think it is a really useful means of getting proactive care for people with chronic disease. So there is definitely benefit, and it is a good first step.[16]

1.37 The AGPN are also supportive of the Government's initiatives in regard to its GP Super Clinic and GP practice infrastructure grants:

> The fact that it has an infrastructure component for existing practices to support existing practices to expand and extend, so that they can house workforce like nurses and allied health professionals, is very, very welcome and something that we advocated for very strongly with the other GP groups through United General Practice Australia.[17]

1.38 Unfortunately the Opposition does not support this policy and would cancel the grants for GP practices and for additional GP Super Clinics.[18]

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15 Mr R Wilson, Member, Australian Health Care Reform Alliance, *Committee Hansard,* 8.6.10, p.46.

16 Mr L Wells, Australian General Practice Network, *Committee Hansard*, 7.6.10, p. 89.

17 Mr L Wells, Australian General Practice Network, *Committee Hansard*, 7.6.10, p. 91.

18 Andrew Robb, Media Release, *Coalition's Plan to rein in Rudd's reckless spending,* 19 May 2010.

Mental Health

1.39 A $176 million package is a part of the NHHN reforms is devoted to specific mental health programs – in addition to the sub-acute bed package referred to in hospital investments. This includes:

- Doubling the number of headspace services from 30 to 60 ($78.3 million) which will provide early intervention and mental health support for an additional 20,000 young people each year.
- Expanding the Early Psychosis Prevention and Intervention Centre model ($24.8 million) with additional state contributions, up to 3,500 young people and their families will benefit from improved detection and earlier treatment and support.
- Supporting additional mental health nurse services ($13 million) over two years for at least 11,700 extra sessions.
- Providing more flexible care under the existing Access to Allied Psychological Services Program ($57.4 million) to provide care to up to 25,000 people with severe mental illness.

1.40 COAG also agreed to undertake further work on the scope for additional mental health service reform for report back in 2011, including the potential for further improvements to the allocation of roles and responsibilities.

Aged Care

1.41 The reforms include landmark investments in aged care:

- the Commonwealth taking full policy and funding responsibility to support the development of a nationally consistent aged care system covering basic home care through to nursing home level care (except in Western Australia and Victoria);
- $96 million over four years to improve access to primary care services for people in aged care;
- improving the viability of community care providers ($10 million);
- 1,200 Consumer Directed Care packages, through which care recipients have a greater say in how services are provided to them; and
- strengthening consumer protections in aged care and toughen prudential requirements to protect residents' savings ($25 million).

Workforce

1.42 As part of the Commonwealth's investment in the health system, there will be delivered a $643 million investment in Australia's health workforce. This investment will train more doctors and support allied health professionals working in rural Australia:

- 1,375 more general practitioners (GPs) practising or in training by 2013, and 5,500 new GPs or GPs undergoing training over the next decade ($339 million);

- 975 places each year for junior doctors to experience a career in general practice during their postgraduate training period ($148 million);
- 680 more specialist doctors over the next decade ($145 million);
- 1,000 extra clinical training scholarships for allied health students over the next decade ($6 million);
- support for up to 1,000 allied health professionals over the next decade to take leave, including to access professional development courses to keep their skills up to date ($5 million).

E-health

1.43 The Government considers the establishment of a secure national electronic personal health record system or 'e-health' to be one of the most substantial reforms to improve the health care system. The e-health reforms are fundamental to the reform package – the Government's investment in e-health will improve patient care, system effectiveness, patient safety and quality of care.

1.44 The e-health reforms are grounded in the recommendations of the National Health and Hospitals Reform Commission which noted in its final report that e-health provides an opportunity to 'improve the safety and quality of health care, reduce waste and inefficiency, and improve continuity and health outcomes for patients'.[19]

1.45 The e-health reforms have been welcomed by stakeholders:

- Ms Carol Bennett of the CHF stated that e-health is an 'absolutely critical plank of this whole health reform process';[20]
- Professor David Penington supported e-health as an 'essential part of making health care more accessible and more reliable so that information is available when people require urgent care';[21]
- Mr Steve Sant of the Rural Doctors Association of Australia (RDAA) argued that e-health has the potential to 'provide some significant supports for rural doctors';[22]
- Mr Vern Hughes of the Australian Health Care Reform Alliance (AHCRC) stated that the introduction of e-health is 'fundamentally important to any kind of health reform';[23] and
- Ms Anne Wise of the CHF argued that e-health was essential to an improved health system and to 'the safety and quality of the health system as it is experienced by consumers'.[24]

19 National Health and Hospitals Reform Commission, *A Healthier Future for All Australians, Final Report*, June 2009, p. 129.

20 Ms C Bennett, Consumers Health Forum of Australia, *Committee Hansard*, 8.6.10, p. 6.

21 Professor D Penington, *Committee Hansard*, 8.6.10, p. 22.

22 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard*, 8.6.10, p. 67.

23 Mr V Hughes, Australian Health Care Reform Alliance, *Committee Hansard*, 8.6.10, p. 47.

1.46 Dr Christine Bennett, former Chair of the NHHRC, argued that e-health was a 'very important if not vital part of the reform'. In recalling her experience in travelling around the country with the NHHRC, Dr Bennett highlighted that the community couldn't understand why there was no e-health record given so much was done in the e-world. She noted that the NHHRC described the person-controlled electronic health record 'as the single most important enabler of truly person-centred health care' and that:

> The reason for that is that you are giving an individual access to their own health information. That is the most important information they can have when making decisions about their health.[25]

The current situation in relation to health record keeping

1.47 This Government has recognised that the current situation is inefficient and has the potential to undermine good patient care. Indeed, Ms Carol Bennett of the CHF stated that:

> We constantly hear stories from consumers about the chaos that they experience, particularly those with chronic conditions, when they are being referred from practitioner to practitioner. Their records are not kept in any kind of system. They have to continuously keep on top of what tests they have had. In some instances they themselves virtually have to become practitioners to keep on top of the information that they need to provide to their practitioners. It is absolutely fundamental that we get some kind of electronic health records system in place to support this range of measures, because if we do not we risk continuing the disjointed arrangements that we have in place that at the end of the day risk patients' safety and make their experiences in navigating the system really difficult.[26]

1.48 Mr Hughes of the AHCRA went further, and argued that the current system is primitive:

> We have no consolidated information system that is applicable across all of the providers and practitioners in the health system. A person with a chronic or complex condition will typically have 20 or 30 practitioners. They will have a filing cabinet somewhere in their office with a few notes in it. Sometimes it will be a bit more elaborate than a few notes. Those things scattered around in the filing cabinets of a city somehow constitute an information system. It is primitive—it is Neanderthal—and it is essential to remove it.[27]

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24 Ms A Wise, Consumers Health Forum of Australia, *Committee Hansard*, 8.6.10, p. 7.

25 Dr C Bennett, Private capacity, *Committee Hansard*, 8.6.10, p. 32.

26 Ms C Bennett, Consumers Health Forum of Australia, *Committee Hansard*, 8.6.10, pp. 6–7.

27 Mr V Hughes, Australian Health Care Reform Alliance, *Committee Hansard*, 8.6.10, p. 51.

1.49 Mr Hughes drew a comparison with the banking system in arguing of the importance of e-health to the health reform package:

> If you imagined a banking system trying to do banking operations without an electronic system, it would be laughable; yet we have exactly that in health. So in my book—and certainly from the point of view of parents, families and carers of people with complex conditions, whom I represent—it is the most fundamental requirement of reform.[28]

1.50 Mr Sant of the Rural Doctors Association of Australia highlighted the difficulties faced by doctors in rural communities without e-health and argued that:

> Things like sharing of medical records, particularly with things like grey nomads, certainly have a potential to improve the health outcomes and remove costs. The number of times where I have been told that a practice has an electronic copy of the records of a patient, they have an electronic copy of their imaging, their x-rays or the pathology results, but they cannot send that to the hospital in the city because the hospital cannot receive it. So having those e-health initiatives in place will help improve that; it will help improve the costs, and it will help improve the outcomes.[29]

1.51 More than 97 per cent of doctors are using software and, as Ms Jane Halton, Secretary, Department of Health and Ageing noted, the e-health reforms will provide the means to 'connect up what actually happens on an individual doctor's desk with what is happening on other doctors' desks'.[30] Ms Halton pointed to the current situation and the consequences of having electronic records in sections of the health sector but not across it entirely:

> Increasingly people are starting to move things like pathology reports around electronically. If I go to see my general practitioner here in Canberra now, if I have been to have pathology tests, she will actually receive those reports electronically. However, what we do not do is make that information available if, for example, heaven forbid, I get knocked over in the basement of Parliament House as I take the shortcut to the basement. If I run in front of one of those little trolleys and have to be carted off to the Canberra Hospital Accident and Emergency department, they cannot easily access my record. They cannot tell whether I am diabetic—I am not, for the record. They cannot tell whether I am on any particular medication. They do not know what my blood group is. They do not know all the things that might be germane to whatever it might be that they decide when I am there. They need to know a whole series of things about me which,

28 Mr V Hughes, Australian Health Care Reform Alliance, *Committee Hansard*, 8.6.10, p. 47.

29 Mr S Sant, Rural Doctors Association of Australia, *Committee Hansard*, 8.6.10, p. 67.

30 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 43.

> without access to an electronic health record, they are going to have start from ground zero to work out. Not only will it save time; it will also be a significant improvement in safety.[31]

The benefits of e-health to consumers and the medical profession

1.52 Under the previous Government, Australia was been very slow to develop e-health. For example, Professor Penington noted that in Finland, 'they have e-health covering all of their prescriptions and patient records over 30 years in full operation this coming year'.[32]

1.53 This Government has recognised the significant benefits of e-health to consumers. As Dr Christine Bennett has noted, e-health means that any health professional that a patient sees will have access to core information from other health professionals:

> Rather than basically carrying around a cardboard box or a folder with whatever scraps of information they can glean from their various health service visits, a person would now have full access to a summary of all of their health professional visits which they can then share, if they choose, with the health professionals they are seeing. This will both empower the patient and make them more involved in their health care and the healthcare decisions. It will also reduce waste and duplication of tests, protect against adverse drug events when prescribing doctors do not realise that someone is on a different drug and they have not got it quite right, and make things more efficient when people go into hospital.[33]

1.54 Mr Hughes of the AHCRA also highlighted the importance of placing the consumer at the centre of e-health in terms of control over their own information:

> What is laudable in the government's intention is that this will be person controlled. I think it is very important that the government hold to that commitment so that a consumer is able to authorise who may access that information. It must not be a prerogative of a provider or practitioner to assume that they can access it. Placing the prerogative with the consumer is an empowerment and a very important shift, but the government will face pressures from hospitals and other practitioners to drop the person controlled dimension. It may drop it. It will depend on the extent to which consumers fight for it.[34]

1.55 In the aged care sector, the benefits of e-health will also be significant. Professor Penington commented:

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31 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 44.

32 Professor D Penington, *Committee Hansard*, 8.6.10, p. 22.

33 Dr C Bennett, Personal capacity, *Committee Hansard*, 8.6.10, p. 32.

34 Mr V Hughes, Australian Health Care Reform Alliance, *Committee Hansard*, 8.6.10, pp 51–52.

> E-health can provide telemedicine with the provision of processes to monitor performance, to monitor falls and new technology even IT can make it simple for people to keep in contact with their families and their friends rather than having them isolated in the home. Those things are necessary and rehabilitation hospitals, the so-called sub acute hospitals, ought to be part of supporting those people with physiotherapy and nursing care most of the time rather than them being dropped into the acute hospitals, sitting there unable to move back to their homes, and blocking beds that are necessary for support of emergency care and the like. There needs to be a more rational approach to aged care and it is primarily a matter of improving quality of life for elderly people who are going to continue to grow in number at a very steady rate over the next 20 or 30 years.[35]

1.56 Ms Jane Halton, Secretary, Department of Health and Ageing, highlighted that an electronic health record system mean will change the way people do their work – patients will not have to repeat their details every time they see a new practitioner, and practitioners will be confident that the details for a patient are accurate. In addition, e-health will enable people to take a more active role in their own health and allow them much more control over how they manage their health issues. Ms Halton concluded:

> The electronic health record is fundamental to all of that. We are very careful and mindful about the issues in respect of privacy. One of the things that we are always reminded of is that people regard privacy as being the most fundamental consideration, so we are building a system that will very carefully protect people's privacy. The ability to actually have health join the information technology revolution is absolutely fundamental to making the whole package succeed.[36]

1.57 The Government's aim to implement the e-health measures now will ensure that there is a consistent approach across Australia. The Government does not want to see different proprietary systems in different jurisdictions that do not communicate with each other. Such an occurrence would fail to deliver the maximum possible benefits to health consumers. As Ms Halton noted:

> It is about everything from ensuring that the email gets through to that what is in the email is understandable and is then loaded into the one record that can be read and understood by anybody you enable access to it. That actually underpins why it is important to do this now.[37]

1.58 Unfortunately this measure does not have bipartisan support and in their budget reply the Liberal and National Parties have decided that they would not

35 Professor D Penington, *Committee Hansard*, 8.6.10, pp 21–22.

36 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 43.

37 Ms J Halton, Department of Health and Ageing, *Committee Hansard*, 7.6.10, p. 44.

support the funding for e-health investments.[38] Such a nearsighted decision misses this important opportunity for reform of the health system and improving the safety and quality of the outcomes for patients.

Conclusion

1.59 The National Health and Hospitals Network represents the most significant change to the health system since the introduction of Medicare. Sadly reform has stalled over the past decade as hospital budgets were tightened as a result of the Howard Government not playing its part in the funding of Australia's hospitals and the blame-game became the norm in health.

1.60 These reforms provide a circuit breaker for the system, which otherwise would be unable to face the coming challenges of the ageing population and the increase in chronic disease.

1.61 The Opposition Senators on this committee claim, for political purposes, that little is changing, yet the clear evidence to the committee from a wide range of witnesses is that there are very strong reforms being implemented that will have a very positive effect on the health of Australians. This is in comparison with the position of the Opposition which is to cut vital investments in e-health and GP practices and Super Clinics which would deprive Australians of much needed health infrastructure.

1.62 We wholeheartedly support the Government's reforms reached at the COAG meeting as driving important structural change, transparency, additional funding, resources and local governance.

1.63 The structural change, transparency, additional funding resources, and local governance will lead to improvements for all who use the Australian Health System.

Senator Helen Polley
Senator for Tasmania

Senator Doug Cameron
Senator for New South Wales

38 Andrew Robb, Media Release, *Coalition's Plan to rein in Rudd's reckless spending,* 19 May 2010.

Minority Report

Senator Rachel Siewert, the Australian Greens

The Australian Greens welcome the intent of the inquiry and the Committee report. There is near universal agreement in the evidence submitted to the inquiry that the new funding for health is significant and is much needed in the health system. However, the degree to which this could be described as reform is debatable. It is not within the scope of this inquiry to determine how the proposed new structure will work but the relationships between the authorities, local hospital networks and Medicare Locals remains unclear. There is insufficient detail on how this will evolve. The inquiry process has made clear that those outside of government service delivery, especially consumers, must be involved in the design of the system.

The Committee's conclusions reiterate a number of the issues the Greens have identified since the reforms were announced. In particular, the Greens have noted the inadequacy of funding for community based mental health services and called for increased funding for this important health area and a universal dental scheme. The inadequate response to mental and dental health reform issues is noted in submissions by The Australian Health Care Reform Alliance, Catholic Health Australia, the AMA, SARRAH and the Consumers Health Forum of Australia.

The following comments by the Committee are strongly endorsed by the Australian Greens:

- *Leadership on mental health was promised by the Commonwealth but what has emerged with the announced reforms is a small, incremental change to the system which will do very little to address inequity in access to services and decrease unmet need for mental health services.*

- *The Committee notes the comments by Professor Patrick McGorry who pointed to the excellent evidence-based programs which are available in this country that, if provided with adequate funding could have a tremendous, positive impact for those Australians with mental illness. In particular, expanded funding for the Headspace and EPPIC programs would see many more young people access services.*

- *The Committee also notes that there is overwhelming evidence that the benefits of providing increased access for young people far outweigh the additional cost to the health budget. The reduction of disability, the improvement in survival rates, the decrease in use of services and improved outcomes point to the high cost effectiveness of early intervention programs.*

Professor McGorry stated that the costs are three times as much over an eight-year period if a person goes through the normal late intervention system.[1]

- *The Committee considers that the Commonwealth has not delivered on its promise of reform of mental health services. Rather, the rhetoric continues and inadequate levels of mental health services remain.*

In addition the Committee's conclusions on aged care reiterate issues the Greens have long championed.

1.0 The provision of care for Australia's ageing population poses significant challenges. The Government's proposed reforms do not address those challenges. They have been formulated before the Productivity Commission has completed its inquiry. The Productivity Commission is not due to report until December 2010.

1.1 In the meantime, the aged care sector is still underfunded and still lacking in certainty about capital funding to ensure that new beds are actually constructed and maintained. The complex funding arrangements remain.

1.2 It is doubtful that the measures to address the issue of long stay older patients will in fact see older people move out of public hospitals. To do so, there needs to be beds for them to go to and more importantly, staff to look after them.

Given that the Government is to redirect $276.4 million funding over three years from high-care residential aged care beds to the states and territories to provide 'similar levels of care' for LSOP in public hospitals, this seems unlikely any time soon.

Senator Rachel Siewert

Senator for Western Australia

1 Professor P McGorry, *Committee Hansard*, 8.6.10, p. 12.

APPENDIX 1

Submissions and Additional Information received by the Committee

Submission	
1	Name Withheld
2	Consumers Health Forum of Australia *Additional Information* Answers to questions on notice from public hearing, 8 June 2010, Melbourne.
3	Catholic Health Australia
4	Australian Diabetes Society
5	Dietitians Association of Australia
6	Services for Australian Rural and Remote Allied Health (SARRAH)
7	Professor David Penington
8	Professor Patrick McGorry *Additional Information* Answers to questions on notice from a public hearing, 8 June 2010, Melbourne.
9	The Society of Hospital Pharmacists of Australia
10	Australian Medical Association
11	Royal District Nursing Service
12	The Royal Australian and New Zealand College of Psychiatrists
13	Social Workers in Private Practice
14	Australian Institute for Primary Care
15	Royal Australian College of General Practitioners *Additional Information* Answers to questions on notice from public hearing, 8 June 2010, Melbourne.
16	Australian Diabetes Educators Association
17	Aged and Community Services Australia
18	Victorian Healthcare Association Limited
19	National Primary Health Care Partnership *Additional Information* Answers to questions on notice from a public hearing, 8 June 2010, Melbourne.
20	Dr Kathryn Antioch
21	Mental Health Council of Australia

22 Rural Doctors Association of Australia

23 Australian College of Mental Health Nurses

24 Departments of Health and Ageing, The Prime Minister and Cabinet, Finance and Deregulation and the Treasury

Additional Information

- Department of Health and Ageing: Answers to question on notice from public hearing, 7 June 2010, Canberra.
- Department of The Prime Minister and Cabinet: Answers to question on notice from public hearing, 7 June 2010, Canberra.
- Department of Finance and Deregulation: Answers to question on notice from public hearing, 7 June 2010, Canberra.
- The Treasury: Answers to question on notice from public hearing, 7 June 2010, Canberra.

25 Carers Australia

26 Australian Institute of Health and Welfare

27 Australian General Practice Network

Additional Information

Answers to questions on notice from public hearing, 7 June 2010, Canberra.

28 Allied Health Professions Australia

29 Australian Self-Medication Industry (ASMI)

30 Australian Health Care Reform Alliance

Additional Information

Answers to questions on notice from public hearing, 8 June 2010, Melbourne.

31 Australian Psychological Society

32 Premier of South Australia

33 Public Health Association of Australia

34 Australian Osteopathic Association

35 Business Council of Australia

36 Doctors Action Inc

Additional Information

- Nelson Plaza Clinic Patient Registration Form: Document tabled at public hearing, Monday 7 June 2010.
- Shoal Bay Public School Snippets: Document tabled at public hearing, Monday 7 June 2010.
- One year on, is the cost of Darzi centres too high? Article from Pulse Today by Gareth Iacobucci: Document tabled at public hearing, Monday 7 June 2010.

37 Dr Joanna Sutherland

Additional Information received by the Committee

1 Senator Concetta Fierravanti-Wells

Additional Information

- South Eastern Sydney/Illawarra Area Health Service: Document tabled at public hearing, 7 June 2010.
- How will Health Reform give us better healthcare and better hospitals?: Document tabled at public hearing, Monday 7 June 2010.
- Answer to Additional Estimates 2009-10 Question on Notice from Department of Health and Ageing, Question E10-234, Advertising and Marketing: Document tabled at public hearing, Monday 7 June 2010.
- 'Coercive contracts to join Super Clinic', article by Jared Reed on 6minutes.com.au: Document tabled at public hearing, Monday 7 June 2010.

2 Australian National Audit Office

Additional Information

Auditor-General's response to committee correspondence regarding the role of the Auditor-General in relation to Local Hospital Networks, 11 June 2010.

3 Dr Christine Bennett

Additional Information

Answers to questions on notice from public hearing, 8 June 2010, Melbourne.

4 Government of Tasmania

Additional Information

Correspondence received from Michelle O'Byrne MP, Minister for Health and Tourism, Government of Tasmania.

APPENDIX 2

Public Hearings/Witnesses

Monday, 7 June 2010
Parliament House, Canberra

Committee Members in attendance:

Senator Scott Ryan (Chair)
Senator Doug Cameron
Senator John Williams
Senator Rachel Siewert
Senator Mary Jo Fisher
Senator Concetta Fierravanti-Wells

Witnesses

Department of Health and Ageing
Ms Sarah HALTON, Secretary
Mr Graeme HEAD, Deputy Secretary
Ms Rosemary HUXTABLE, Deputy Secretary

Department of Finance and Deregulation
Mr David de CARVALHO, First Assistant Secretary, Social Policy Division, Budget Group

Department of the Treasury
Ms Peta FURNELL, Deputy Secretary

Department of the Prime Minister and Cabinet
Mr Benjamin RIMMER, Deputy Secretary

Catholic Health Australia
Mr Martin LAVERTY, Chief Executive Officer
Mr Nicolas MERSIADES, Senior Adviser, Aged Care
Mr Patrick TOBIN, Director, Policy

Rural Doctors Association of Australia
Mr Steve SANT, Chief Executive Officer

Doctors Action
Dr Adrian SHEEN

Australian General Practice Network
Ms Leanne WELLS, Executive Director
Ms Rachel YATES, Director Policy

Mental Health Council of Australia
Mr David CROSBIE, Chief Executive Officer
Mr Simon TATZ, Director of Communications

Australian Medical Association
Dr Andrew PESCE, President
Mr Francis SULLIVAN, Secretary-General

Tuesday, 8 June 2010
Stamford Plaza, Melbourne

Committee Members in attendance:

Senator Scott Ryan (Chair)
Senator Helen Polley (Deputy Chair)
Senator Helen Kroger
Senator Rachel Siewert
Senator Concetta Fierravanti-Wells

Witnesses

Consumers Health Forum of Australia
Ms Carol BENNETT, Executive Director
Ms Anna WISE, Senior Policy Manager

Professor Patrick McGORRY

Emeritus Professor David PENINGTON

Dr Christine BENNETT

Royal Australian College of General Practitioners
Dr Morton RAWLIN, Vice-President

Australian Health Care Reform Alliance
Mr Vern HUGHES, Committee Member
Mr Bo LI, Executive Member
Mr Rod WILSON, Member

National Primary Health Care Partnership
Ms Claire HEWAT, Chair
Prof. Lyndel LITTLEFIELD, Member
Ms Leanne WELLS, Member