



Australian Government

A NATIONAL HEALTH AND HOSPITALS NETWORK FOR AUSTRALIA'S FUTURE



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***A NATIONAL HEALTH AND
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FOR AUSTRALIA'S FUTURE***



FOREWORD

This Government was elected with a mandate to prepare Australia for the challenges of the future.

One of our greatest challenges is to ensure that future generations will enjoy world class, universally accessible health care — the quality of care that has helped deliver Australians the third longest life expectancy in the world.

As this document makes clear, Australia's health and hospital services are struggling to keep pace with the unrelenting growth in demand.

The Third Intergenerational Report released this year showed that these pressures will only intensify as a result of the ageing of the population. In addition, demand for high standards of care will place pressure on the Government to increase expenditure, as will technological innovation.

Without major changes, as rising health costs outstrip revenue growth, state budgets will be at risk of being overwhelmed.

If Australians are to continue to enjoy access to world class health care, we must undertake far reaching reform of our health and hospital system now.

The Government's National Health Reform Plan will deliver the most significant reforms to health and hospitals since the introduction of Medicare. It will also deliver one of the biggest reforms to the federation in its history. It will provide better health and better hospitals.

This document sets out major structural reforms to establish the financing and governance foundations of a National Health and Hospitals Network for Australia's future.

The Government expects that these reforms will permanently establish the Commonwealth Government as the majority funder of hospitals and place the Australian health system onto a sustainable and self-improving footing for the future.

They will create a nationally unified and locally controlled National Health and Hospitals Network.

The National Health and Hospitals Network will build on the major health reforms the Government has already delivered: record funding for public hospitals, increased numbers of elective surgery procedures, taking the pressure off emergency departments, and a record investment in training more doctors and nurses.

The reforms will also build on the strengths of our current health system, such as access to primary health care through Medicare, and free public hospital treatment for public patients — and ensure that these remain sustainable into the future.

The National Health Reform Plan represents not just reform to health and hospitals — this is also a major economic reform that will underpin the sustainability of public finances in our federation.

We thank Dr Christine Bennett and her fellow Commissioners for their work on *A Healthier Future for all Australians*, the National Health and Hospitals Reform Commission's Final Report, which provides the roadmap for our National Health Reform Plan.

The Australian Government is committed to acting now to tackle our nation's long-term challenges. The National Health and Hospitals Network will play a key role in tackling those challenges and building Australia's future — so that all Australians can enjoy access to high quality, efficient and sustainable health care in the decades ahead.



The Hon. Kevin Rudd MP
Prime Minister



The Hon. Wayne Swan MP
Treasurer



The Hon. Nicola Roxon MP
Minister for Health and Ageing

March 2010

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OVERVIEW

1. A NATIONAL HEALTH AND HOSPITALS NETWORK FOR AUSTRALIA'S FUTURE


The Commonwealth Government's National Health Reform Plan will deliver the most significant reforms to Australia's health and hospital system since the introduction of Medicare and one of the biggest reforms to the federation in its history.

This document sets out the architecture and foundations of the Government's historic National Health Reform Plan, which will deliver major structural reforms to establish the foundations of Australia's future health system.

These major structural reforms will mean that the Commonwealth Government:

- › becomes the majority funder of public hospitals;
- › takes over all funding and policy responsibility for GP and primary health care services;
- › dedicates around one third of annual Goods and Services Tax (GST) allocations currently directed to state and territory governments (referred to throughout this document as 'states') to fund this change in responsibilities for the health system;
- › changes the way hospitals are run, taking control from central bureaucracies and handing it to Local Hospital Networks; and
- › changes the way hospitals are funded, by paying Local Hospital Networks directly for each hospital service they provide, rather than by a block grant from the Commonwealth to the states.

These reforms focus on improving public hospital and primary health care services, since these services underpin Australia's entire health system. They will drive major improvements in service delivery as the Government goes about building a new health and hospital system for the future. The reforms will build on the strengths of our current health system, such as access to primary health care through Medicare, and free public hospital treatment for public patients, and ensure that these pillars of the Australian health system remain sustainable into the future. Most importantly, they will build on the skills, experience and ingenuity of the Australians who work on the front line of our health and hospital system.



The National Health Reform Plan will build on the major health reforms the Government has already delivered: record funding for public hospitals, increased numbers of elective surgery procedures, taking the pressure off emergency departments, and a record investment in training more doctors and nurses.

Reform is necessary if we are to continue to deliver high quality health care. Our current health care system is fragmented, contributes to cost-shifting between different levels of government, involves too much waste, and results in long waiting times for patients.

Our rates of hospital admission are much higher than comparable countries, indicating we can do better at keeping people healthy in the community. The health care system also faces a formidable set of future challenges — an ageing and growing population, rapid innovations in technology that drive increased health costs, and growth in the burden of chronic disease.

Without reform, these challenges will put governments around the country under increasing fiscal pressure, add to the workload of already overstretched staff and lead to longer waiting times. Moreover, there is a real risk that state governments will be overwhelmed by their rising health spending obligations, as a result of rapidly rising costs for health and hospitals and narrower, less efficient taxes — putting our health system at risk. Reform of the nation's health care system — if it is to provide a sustainable funding model for health and hospitals — must involve reform of the nation's finances.

In implementing its reforms, the Government recognises the importance of continuing the role that private hospitals and other private health care providers play in delivering strong health outcomes.

The Government is prepared to address the current and future challenges facing our system. This reform package builds on the recommendations of the National Health and Hospitals Reform Commission (NHHRC), and more than 100 consultations the Government has conducted with health professionals and the community. It represents the system-wide reforms upon which additional investments will build over the course of 2010. This reform package is the position the Government will take to states for their agreement at the next meeting of the Council of Australian Governments (COAG) in April.

2. PROBLEMS WITH OUR HEALTH SYSTEM TODAY

2.1 *A system that isn't prepared for future challenges*

While Australia's health system serves most Australians well, at a cost to the community that is around the average of other advanced nations, it is facing a number of serious challenges:

- › An **ageing population** will substantially increase both health care needs and expenditure, while further constraining our health workforce. The 2010 Intergenerational Report forecasts the proportion of our population aged over 65 will increase from 14 per cent in 2010 to 23 per cent by 2050.
- › Our **population is projected to grow** from 22 million people today to 36 million by 2050. This growth will create the need for more health services, new investment in health infrastructure and an expanded health workforce.
- › **Chronic disease** is a large and increasing burden on our health system. For example, the cost of type two diabetes is projected to increase by more than 520 per cent from 2002–03 to 2032–33.
- › **Costs have increased sharply** in recent years and are expected to continue growing. The 2010 Intergenerational Report projects health costs to increase from 15 per cent of all Commonwealth Government spending now (4.0 per cent of GDP) to 26 per cent by 2050 (7.1 per cent of GDP).
- › **Workforce shortages** are already placing limitations on the delivery of health care — particularly in regional and rural Australia. As well as training more health professionals, we will need to be more effective at making the most of the skills and dedication of our existing health workforce.

2.2 Too much blame and fragmentation between governments

In effect, Australia currently has eight different state and territory health systems. The distribution of responsibilities for health between different levels of government is blurred and unclear, resulting in duplication, cost-shifting and blame-shifting. The relative financial contributions of different levels of government to hospital services are fiercely disputed, especially when hospital funding arrangements are negotiated.

Further, patients find it hard to work out which level of government is accountable for their care, when all they want is the services they need. Clear boundaries need to be set between the responsibilities of each level of government, and services designed accordingly.

2.3 Gaps and poor coordination in health services that people need

Too many patients are either falling through the gaps or receiving uncoordinated care. Changes that streamline the delivery of care and remove fragmentation in services are long overdue, particularly for people living with chronic disease.

In addition, not all Australians get the services they need. People living in rural and regional areas, for example, sometimes struggle to access primary health care. Many people are unable to access out of hours GP services. Some groups in our community, such as Indigenous Australians and those living in highly disadvantaged areas, have poor health outcomes, and are unable to access appropriate care.

2.4 Too much pressure on public hospitals and health professionals

Our public hospital system is struggling to cope with growing patient demand and stretched budgets. For more than half a decade, almost one in six elective surgery patients and one in three people attending emergency departments have been waiting longer than the recommended time for treatment. Australia's rates of hospital admission are above the Organisation for Economic Cooperation and Development (OECD) average and significantly higher than comparable countries such as the United States, New Zealand, and Canada. This pressure and constant strain on resources is also felt in the everyday working lives of health professionals.

These problems are not likely to be resolved through incremental funding and policy changes. New arrangements that fundamentally change the way hospitals are funded and run are needed to ensure additional hospital capacity, greater efficiency, and better services.

2.5 An unsustainable funding model

The cost of providing health care is expected to continue to increase into the future. But state government revenue growth is not keeping pace with growing health care costs.

In the five years to 2007–08, public hospital expenditure has grown at an average of close to ten per cent per year. Projections show that by 2045–46, health spending alone would be more than all revenue collected by state and local governments — and that in some states, this will happen earlier. Strong action is needed to ensure the sustainability of health care funding.

2.6 Too much inefficiency and waste

Waste and inefficiency are ongoing challenges for the health system. The Productivity Commission estimates that some public hospitals may be running up to 20 per cent less efficiently than best practice. Costs per patient vary between state public hospital systems, suggesting efficiency in some states is better than in others.

The Commonwealth Government currently funds states with block grants for public hospital services. Despite recent improvements through the National Healthcare Agreement, the transparency of health care funding and spending is still relatively limited. This lack of transparency means taxpayers and the governments that serve them are unable to make robust comparisons across states, or easily identify where there is inefficiency.

Part of the problem is overly centralised and bureaucratic administrative arrangements for hospitals in some states, which sap the innovation and drive of local clinicians and managers, and reduce incentives to improve performance.

2.7 Not enough local or clinical engagement

Many clinicians and citizens are not adequately involved in decisions about the delivery of health services in their local community. Current arrangements fail to make the most of the expertise and commitment of our clinical workforce. It also means that some services are poorly tailored to community needs. Decisions made at a local level, with appropriate clinician and community engagement concerning service mix and delivery options, can bring significant improvements in both productivity and service quality.

3. BUILDING ON MAJOR REFORM

In its first two years in office, the Government has undertaken major reforms across health and hospitals: increasing funding for public hospitals, targeting key pressure points such as emergency departments and elective surgery and training more doctors and nurses.

3.1 *Increased funding for health and hospitals*

In November 2008, the Government signed a \$64 billion agreement for health and hospitals funding over the next five years, which delivered a 50 per cent increase on the previous Australian Health Care Agreements. Additional funding was linked to a range of performance indicators across prevention, primary and community care, hospital and related care, aged care, the patient experience and sustainability. States agreed to national outcomes and outputs, challenging new targets, and increased service levels.

The agreement also included:

- › **\$1.1 billion to train more doctors, nurses and allied health workers** in the largest single investment in the health workforce.
- › **\$750 million to take pressure off emergency departments** with an agreed performance benchmark that by 2012, 80 per cent of emergency department presentations will be seen within the clinically recommended time for treatment. Thirty seven hospitals around the country are receiving upgrades as a result of this investment.
- › **\$500 million for sub-acute care facilities** including rehabilitation, palliative care, geriatric evaluation and psychogeriatric services.

In addition, the Government has invested **\$600 million in an elective surgery waiting list reduction plan** that has already delivered more than 62,000 additional procedures and new elective surgery equipment and operating theatres for 125 hospitals.

3.2 More doctors, nurses and allied health professionals — and making smarter use of our health workforce

As part of the November 2008 COAG agreement, the Government has made an unprecedented investment in training more doctors, nurses and allied health professionals.

This includes:

- › raising the number of GP training places to a total of 812 by 2011 — a 35 per cent increase on the limit imposed since 2004;
- › 73 additional specialist training places in the private sector each year;
- › additional funding to train nursing, allied health and medical supervisors; and
- › establishing Health Workforce Australia to plan for future workforce needs.

The Government has also undertaken reform to make smarter use of our workforce by providing nurses and midwives with access to the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme.

3.3 Comprehensive health care that is close to home through GP Super Clinics

To provide comprehensive services close to home, 36 GP Super Clinics are being built across the country. GP Super Clinics bring together GPs, nurses, visiting medical specialists, allied health professionals and other health care providers to provide integrated, multidisciplinary care in a single convenient location. This infrastructure will particularly benefit Australians with chronic and complex diseases.

3.4 Focusing on prevention rather than cure

The Government has made an \$872 million investment in preventative health programs to be rolled out in schools, workplaces and local communities with a high incidence of chronic disease. These programs will focus on reducing lifestyle risk factors such as smoking and obesity and increasing physical activity and healthy eating. This investment included the establishment of a National Preventative Health Agency, to advise all governments on the evidence base for future investments in prevention.

To tackle binge drinking amongst young people, the Government has increased the excise on ready-to-drink beverages and implemented a National Binge Drinking Strategy.

3.5 Closing the life expectancy gap between Indigenous and non-Indigenous Australians

To help close the gap between Indigenous and non-Indigenous health outcomes, the Commonwealth, states and territories are investing \$1.6 billion in measures to reduce the burden of chronic disease in the Indigenous population — the biggest contributor to the life expectancy gap. These measures include support for tackling high rates of smoking in the Indigenous community, and improving management of chronic diseases such as diabetes through additional support for primary health care practices with Indigenous patients.

3.6 Addressing workforce shortages in regional and rural Australia

The Government has recognised the challenges faced by Australians living in regional and rural areas in accessing basic health care services. As part of a \$134 million investment, some 500 communities will benefit from a number of new initiatives, which means that around 2,400 doctors in rural Australia will, for the first time, become eligible for financial support to stay in rural and remote areas.

3.7 Investing in hospitals, medical research and clinical training infrastructure

In the first ever major investment by a Commonwealth Government in state health infrastructure, \$3.2 billion has been invested in 35 infrastructure projects across the country, including:

- › \$1.5 billion to upgrade 18 hospitals around the country, including Nepean Health Services Redevelopment — \$96.4 million; expansion of Townsville Hospital — \$250.0 million; and the Health and Medical Research Institute at Royal Adelaide Hospital — \$200.0 million.
- › \$1.3 billion over six years to modernise Australia's cancer infrastructure — including two comprehensive cancer centres in Sydney and Melbourne linked into a network of regional cancer centres.
- › \$430 million to upgrade 12 medical research and clinical training facilities.

3.8 Sustainable, high quality aged care

The Government is committed to sustainable, high quality aged care and to providing funding for more services to older Australians. This year, the Government will make more than 12,000 new aged care places available, with a strong focus on community care.

Over its first two Budgets, the Government increased total funding for aged and community care from \$8.3 billion in 2007–08 to \$10.0 billion in 2009–10, an increase of around 20 per cent. This included:

- › \$300 million in zero real interest rate loans for residential aged care places in areas of need; and
- › 2,000 transition care places to provide restorative care for long-stay older patients in public hospitals, free up acute care beds in public hospitals and provide more tailored support to prepare older patients for discharge back to their homes or aged care services.

3.9 A more financially sustainable health system

The Government has undertaken reforms to health care spending to ensure our system remains fair and sustainable into the future. This includes:

- › rebalancing support for private health insurance, so that those with greater capacity to pay do so — this is expected to save \$100 billion over the next 40 years, with private health insurance coverage expected to remain at around 99.7 per cent of existing levels; and
- › capping areas of the Extended Medicare Safety Net where there have been excessive fee increases.

4. LISTENING TO THE COMMUNITY AND EXPERTS


At the same time as making investments to fix immediate gaps, the Government set in train long-term, system-wide health reform. It commissioned the most comprehensive structural review of Australia's health and hospital system in 20 years, by establishing the National Health and Hospitals Reform Commission.

The NHHRC's final report, which was released at the end of July 2009, contained 123 recommendations for immediate and longer-term reforms. It emphasised the need to focus on three main 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.

Following the release of the NHHRC report, the Government undertook an extensive consultation process to test the report's recommendations with patients, health professionals and the Australian people. In 2009 and 2010, the Prime Minister, the Health Minister, other Ministers and senior officials conducted more than 100 consultations with patients, health professionals and the public.

The Government has also consulted on the development of this plan with state and territory governments through the COAG process. At the COAG meeting in December 2009, the Commonwealth and states agreed that long-term health reform is needed to deliver better services, more efficient and safer hospitals, and more responsive primary health care.



The Government has listened carefully to the expert advice and views put forward by the Australian community. Key feedback from consultations indicated a community desire for:

- › a stronger Commonwealth Government leadership role, coupled with higher standards and increased funding for public hospitals;
- › reduced health sector bureaucracy, simplified governance and accountability, and greater autonomy and flexibility at the local level;
- › better access to multidisciplinary primary health care;
- › better public hospital services and shorter waiting times;
- › better access to health care in rural Australia and disadvantaged areas; and
- › improved integration of information technology across our health system.

Another source of expert input has been the 2010 Intergenerational Report. This report projected that growth in all categories of Commonwealth health spending would increase, driven by population growth and ageing, increased demand for health services, and new technology. The report forecasts that rising health costs will be by far the largest contributor to increased Commonwealth spending to 2050, accounting for around two-thirds of the overall increase in Commonwealth spending. This is consistent with, and reinforces the conclusions of, the previous two Intergenerational Reports. It provides further evidence that the ongoing sustainability of the system will be challenging.

5. REFORMS TO ESTABLISH THE FOUNDATION OF A NEW HEALTH SYSTEM

The policy positions outlined in this section represent the proposal the Government will put to states at COAG in April. These reforms will equip the system to serve Australians well into the future, by building the foundation for effective future investment in health and hospitals.


5.1 *Taking majority funding responsibility for public hospitals*

The Commonwealth Government will become the majority funder of the Australian public hospitals system. The Commonwealth will fund:

- › **60 per cent of the efficient price of every public hospital service provided to public patients;**
- › **60 per cent of recurrent expenditure on research and training functions undertaken in public hospitals;**
- › **60 per cent of capital expenditure, both operating capital and planned new capital investment, to maintain and improve public hospital infrastructure; and**
- › **over time, up to 100 per cent of the efficient price of 'primary health care equivalent' outpatient services provided to public hospital patients.**

For the first time, the Commonwealth will take clear financial leadership in the hospital system. The Commonwealth will fund 60 per cent of the efficient price of every public hospital service delivered in Australia. This is a fundamental change from the current contribution of around 35 per cent provided under the National Healthcare Agreement. The Commonwealth's increased financial stake will provide leverage for system reform and a secure funding base for public hospitals into the future. In particular, this reform will permanently reverse the decline in the Commonwealth funding contribution for public hospital services over the past decade and put an end to the blame game over hospital funding.

Consistent with the NHHRC's recommendations, the Commonwealth will use its strengthened financial position in the hospital system to drive system-wide reform and create a better integrated, more unified national health system, with national standards and increased transparency and accountability. These changes will ultimately improve performance and health outcomes.



States will continue to be responsible for meeting the remaining costs of public hospital services, including meeting any costs over and above the efficient price, as well as the remainder of research, training and capital costs. This funding split creates a strong incentive for states to be as efficient as possible in playing their ongoing role in our public hospital system.

The Commonwealth will work with states to implement these new arrangements. These sweeping changes to hospital funding responsibilities will help address the challenges facing our health and hospital system. They will end the blame game, provide an unprecedented basis for national leadership of a unified health system, and ensure that incentives and responsibilities for delivering high quality, efficient health and hospital services are appropriately balanced across the federation.


5.2 Taking full funding and policy responsibility for GP and primary health care

The Commonwealth Government will take full policy and funding responsibility for GP and primary health care services in Australia.

This important structural change to roles and responsibilities within the health system means that one level of government — the Commonwealth — will be responsible and accountable for the strategic direction, planning and public funding of primary health care, as recommended by the NHHRC.

Currently, the Commonwealth subsidises privately provided GP and some nursing and allied health services. States provide a range of services including community health centres, subsidised GP clinics, allied health services, child and maternal health clinics, drug and alcohol services, and community mental health services.

Over time, this arrangement has resulted in duplication of effort by Commonwealth and state governments in some areas and delivery gaps in others. Consequently, primary health care services are not as effective as they need to be. This means that many patients — particularly those with chronic and complex conditions, and those who are most disadvantaged — end up in hospital, when they could have received better care in the community.



The failure to provide adequate care in the community puts pressure on our hospital services. Australia's hospitalisation rate is higher than many comparable countries. In 2007–08, there were an estimated 441,000 hospital admissions each year (9.3 per cent of total admissions) that could have been avoided through providing better care in the community.

As a result of taking full funding responsibility for all GP and primary health care services, the Commonwealth will be able to draw services together so they are better integrated, better coordinated, and more responsive to the needs of patients. In practice, this may mean being able to bring state community health services and Commonwealth funded services together in the one setting, such as a GP Super Clinic.

Locating primary funding responsibility for all GP and primary health care services with the Commonwealth Government will allow services to be provided in the most appropriate care setting for the patient, breaking down the artificial barriers that are created by having multiple funders. This change will:

- › improve the efficiency of the system;
- › reduce cost-shifting and blame-shifting, as the Commonwealth Government will be clearly accountable for GP and primary health care services in Australia;
- › allow the Commonwealth to reduce duplication of services, improving efficiency and reducing waste in primary health care; and
- › make it easier for patients to receive the services they need, improving patient outcomes.

Some hospital outpatient services are better characterised as part of the primary health care system. Within its new hospital funding arrangements, the Commonwealth will initially fund 60 per cent of the cost of these 'primary health care equivalent' outpatient services, and move over time to fund up to 100 per cent of the efficient price of these services. This change will make the Commonwealth Government financially responsible for ensuring that patients who do not need to visit a hospital can receive treatment in more convenient and less costly locations.

The Commonwealth will work with states to implement these new arrangements, including setting appropriate boundaries between primary health care and acute care, and primary health care and community care, including the Home and Community Care Program.

5.3 Rebalancing financial responsibility in the federation

As part of its increasing responsibility for health care funding and services, the Commonwealth Government will dedicate around one-third of total GST revenue directly to health spending, and fund the majority of growth in health and hospital costs.

The establishment of a National Health and Hospitals Network is vital to ensure the long-term sustainability of Australia's finances and the capacity to provide high-quality health services into the future.

The Australian Government will take majority financial responsibility for the health and hospital system — paying 60 per cent of the efficient price of all public hospital services and full financial and policy responsibility for GP and related services.

Over the first five years of the reforms, approximately \$90 billion in GST revenue will be dedicated to health and hospital spending, invested through a new National Hospitals Fund that will be clearly identified and detailed in Commonwealth Budget papers.

Because the GST does not keep up with the growth in health care costs, the Commonwealth Government will play an even more important role in financing future health and hospital services in Australia.


Hospital costs have been growing at close to ten per cent per annum, and are expected to continue to outpace growth in GST of around six per cent per annum over the medium term.

These new arrangements represent a fundamental change to federal financial relations, which will help underwrite the sustainability of the health system, better balance fiscal responsibilities across the federation and lead to economy-wide efficiencies.

The 2010 Intergenerational Report, *Australia to 2050*, warned of the impact of burgeoning health costs on the future of the Australian economy and the critical need for financing reform of the health system to prevent it from collapsing under its own weight.

Without fundamental reform there is a real risk that state governments will not have the financial capacity to meet health spending obligations in the longer term — placing our health system and hospital services at risk.

If current trends continue, by 2045–46 spending on health and hospitals would consume the entire revenue raised by state governments. This means that states would not be able to fund their health and hospital system, let alone meet their other responsibilities.



By ensuring that the Commonwealth takes on greater financial responsibility for the health and hospital system, these reforms respond to this important national challenge.

The Commonwealth's increased funding role will put funding for our health and hospital system on a sustainable footing, and provide states with more scope to invest in other services such as roads and schools.

In responding to the challenge the Commonwealth is also improving the long run productivity of the national economy.

These reforms mean the level of government in Australia with the most stable and efficient means of raising revenue will now be the majority funder of the fastest growing area of public expenditure.

In order to help address the challenge of rising health care costs, the Government will also pursue greater efficiencies in health and hospitals — most notably through the introduction of activity based funding and reforms to primary health care services.

Under this reform, no state will be worse off over the upcoming forward estimates and all will be better off in the medium term. Over the period between 2014-15 and 2019-20 the projected benefit to the states and territories is in the order of \$15 billion.

The reforms are consistent with the Government's fiscal strategy as it is fully funded over the forward estimates and consistent with returning the Budget to surplus by 2015–16, while keeping the share of taxation to GDP on average below 2007–08 levels. Fiscal sustainability will be delivered through the Government's commitment to ensure that real growth in spending is constrained to two per cent once the economy returns to above trend growth and until the Budget returns to surplus.

The proportion of GST directed to health care will be fixed over time from 2013–14. This proportion will be determined over the upcoming forward estimates by the spending on health in each state, but in the aggregate will represent around one-third of the GST. The total GST pool will continue to be distributed across the states in accordance with relativities recommended by the Commonwealth Grants Commission.

Final arrangements on this matter will be discussed with the states.

5.4 National standards for a unified health system

The Commonwealth Government will require strong national standards and transparent reporting in the health system, including for emergency department and elective surgery waiting times, bed occupancy rates, reporting of adverse events and hospital acquired infections.

The Government will use its position as the majority funder of health and hospital services in Australia to impose strong national standards for health care and build a nationally unified health system. This was an important theme in the NHHRC's report.


These national standards will apply across the health system, in key areas including:

- › access to public hospital care, particularly emergency departments and elective surgery;
- › access to local GPs and other health professionals;
- › financial performance and efficiency; and
- › safety and quality in the health system.

Strong national standards will help ensure consistent, high-quality health care, and provide greater levels of transparency and information about the health system to increase accountability and drive improved outcomes. Increased information will help consumers to make more informed choices about their health services.

Improved clinical governance will be a key feature of the new system. Services that are of low quality, unsafe or based on poor evidence result in poorer care for patients, and increased cost to the system. Governments need to support clinicians to lead the drive towards continuous improvement in quality and safeguarding high standards of care, as they are the experts in this field.

Central to delivering a nationally unified health system will be increased transparency through the establishment of three national governance functions: an independent pricing function; a performance reporting and auditing function; and a clinical standards function (evolving from the Australian Commission on Safety and Quality in Health Care). These national governance functions will deliver significantly enhanced accountability for public and private hospitals. Clear and consistent information, released at least annually, will mean that Local Hospital Networks are held accountable for meeting performance standards. States will also be subject to more rigorous and transparent performance reporting to the Australian community.



This and other performance information — including on the Commonwealth Government’s performance in primary health care — will be publicly released to provide Australians with more information than ever before about the performance of their health system. Over time, the Commonwealth will seek to strengthen the link between performance and funding.

As part of its national leadership role, the Commonwealth will be alerted to poorly performing hospitals (for example, in the event of continuing failure to meet emergency department targets, or poor quality and safety outcomes) and will require states to step in and fix these problems.

A particular area of concern and variability in the performance of the eight states and territories has been access to emergency departments and elective surgery. The Commonwealth will increasingly look to insist on higher national standards of performance, more consistently applied across the country, with new targets backed up by explicit financial rewards and penalties.

5.5 Local Hospital Networks to drive accountability and performance

Responsibility for hospital management will be devolved to Local Hospital Networks made up of small groups of local hospitals that collaborate to deliver patient care, manage their own budget and are held directly accountable for their performance.

As an integral part of system-wide reform, the Government will require that states introduce Local Hospital Networks — small groups of public hospitals with a geographic or functional connection, large enough to operate efficiently and provide a reasonable range of hospital services.

Local Hospital Networks will avoid the fragmentation and duplication that would come from individual hospitals operating independently from other hospitals in their area, and also avoid centralised controls and excess layers of bureaucracy. Devolving decision making to Local Hospital Networks will give communities and clinicians a greater say in how their hospitals are run, and avoid the sometimes rigid management by remote health bureaucracies.

Local Hospital Networks will be separate state statutory authorities. They will comprise between one and four hospitals in most networks, with regional networks potentially including more small hospitals. These networks will typically be built around principal referral hospitals in major cities or regional centres, and specialist hospitals such as children’s hospitals. In consultation with local communities, states will have the flexibility to determine the regional, rural and remote network structure that best meets the needs of these communities and best takes into account the challenges of managing multiple small hospitals. This will include deciding whether

to incorporate smaller regional and remote hospitals within larger Local Hospital Networks, or whether to create further networks.

The decentralisation of hospital management will play a vital role in strengthening hospitals. Networks will increase accountability by having a professional Governing Council and a Chief Executive Officer responsible for delivering agreed services and performance standards. Increasing local accountability will drive improvements in performance, as management is empowered to make day to day operational decisions that would have otherwise been made by a central bureaucracy. Governing Councils will include local health, management and finance professionals, with an appropriate mix of skills, expertise and backgrounds. Members will need to have the professional capability to run large, complex organisations.

Clinical leadership will be an integral part of Local Hospital Networks. There will be clinical representation on the Governing Council, and Local Hospital Networks will work with local clinicians to incorporate their ideas and perspectives, especially on quality and safety, into the day to day operation of the hospitals.


Local Hospital Networks will be obliged to work with local primary health care providers and aged care providers to ensure that locally responsive and tailored care extends beyond hospital doors. Networks will also collaborate with local private hospitals.

5.6 Paying Local Hospital Networks directly for the services they provide

The Commonwealth Government will pay Local Hospital Networks directly on the basis of an efficient price per hospital service, determined by a new independent national umpire. This should reduce waste and increase the number of services provided for each dollar invested.

The Commonwealth will directly fund Local Hospital Networks for 60 per cent of the efficient price of each service a Network provides to a patient, using a system of activity based funding. This arrangement will ensure each Local Hospital Network is funded for the services it provides. It will provide hospitals with a strong financial incentive to provide more services, subject to meeting safety and quality standards. Local Hospital Networks will work with states to determine the range and number of services each Network will provide.

Currently, the Commonwealth Government provides block hospital funding to states, who then determine how and where this money is spent. With these reforms, the Commonwealth will fund a share of every service that Local Hospital Networks provide.



These reforms will provide the Commonwealth, and the taxpayer, with the confidence that scarce health dollars are being used as efficiently and effectively as possible. It will drive hospitals to eliminate waste and ensure that each additional dollar funds more hospital services, rather than overheads. It will mean an increase in the effective number of hospital beds in the system, and is an essential part of tackling elective surgery waiting lists.

The introduction of activity based funding for hospital services was recommended by the NHHRC as one of the most important drivers of efficiency within the health system.

To minimise disruption in hospital services and ensure that no state is worse off, the Commonwealth Government will transition to activity based funding over time. From 2011–12, the Commonwealth will pay states 60 per cent of recurrent public hospital expenditure. In 2012–13, the Government will then move to directly paying Local Hospital Networks 60 per cent of a state-specific price for each service they provide.

Over time, the Government will shift from a state-specific price and phase in payment of 60 per cent of a nationally efficient price for each service a Local Hospital Network provides. In taking this path, the Government will accelerate and extend the activity based costing approach agreed with states at COAG in November 2008, and apply that model to funding on a national basis.

An independent umpire at arm's length from Commonwealth and state governments will set the nationally efficient price. The independent umpire will be charged with striking an appropriate balance between the sustainability of the hospital system, reasonable levels of access, clinical safety, efficiency, and the significant fiscal impact that hospital funding will have for both the Commonwealth and the states. The price will be adjusted to recognise particular circumstances and health care needs, for example people living in rural Australia and Indigenous Australians.

Local Hospital Networks that deliver high quality services more efficiently will be able to reinvest in further innovation or services.

This transparent and nationally consistent approach to hospital funding will give Local Hospital Networks flexibility to shape local service delivery according to local needs. Through greater transparency and the direct funding of services actually provided, local communities will have more information than ever before on what services a hospital provides, how they are performing, and how they are spending their budgets. This increased information will allow ready identification of high-performing hospitals, which would then be able to share their effective and innovative practices with other hospitals, helping to create a self-improving hospital system.

6. A COMPREHENSIVE REFORM PLAN

The reforms outlined above will provide the architecture and foundation of a National Health Reform Plan to meet Australia's future health needs.

These important structural reforms will create a nationally unified health system, which is locally controlled and majority Commonwealth funded.

The reforms outlined in this document address the need, identified by the NHHRC, to redesign our health system so that it is better positioned to respond to emerging challenges. These reforms will lay the foundations for an effective, efficient health system that governments and taxpayers can be confident will be sustainable into the future.

Over the coming weeks and months, the Government will announce additional reforms that will build on existing investments and the structural reforms outlined in this document. These reforms will be made across a range of areas, including in:

- › **public hospitals**, especially public hospital emergency departments and access to elective surgery;
- › **GP and primary health care**, in particular improving coordination of GP and other kinds of health care for people with chronic illness;
- › **the health workforce**, to ensure there are sufficient numbers of well-trained doctors, nurses and allied health professionals to meet the growing demand for health services; and
- › **e-health**, to take further steps towards the introduction of a personally controlled electronic health record for all Australians.

Over time, the Government will build on existing investments in prevention, aged care, dental health and mental health.

Additional funding directed to the Government's reforms will be provided consistent with the Commonwealth Government's fiscal rules, including holding spending growth to two per cent in real terms.

7. TAKING A REFORM PLAN TO THE STATES

Since November 2007, the Commonwealth Government has worked closely with states to deliver much-needed improvements to the Australian health system. Through cooperation and agreement, the Commonwealth and state governments have been able to address several key pressure points in the health system, including a lack of services, long waiting lists, workforce shortages and increasing demands on public hospital services. In particular, governments agreed the 2008 National Healthcare Agreement, which represented a \$64 billion commitment for health and hospitals and a 50 per cent increase on the previous Australian Health Care Agreements.

However, more work is required to ensure the long-term sustainability and quality of Australia's health system. The Commonwealth Government calls on state governments to continue their cooperation in implementing the necessary reforms contained in this National Health Reform Plan. The Commonwealth Government will continue working closely with state governments through the COAG process to ensure the Plan is implemented as quickly as possible. These essential reforms are required as building blocks for future reforms and to ensure that additional investment in the system is used efficiently and effectively.

In return for its greatly increased funding contribution as set out in this document, the Commonwealth will require the states to make substantial changes. The Commonwealth will be putting this plan to states at COAG in April. Should the states not agree to the Plan, the Commonwealth reserves its right to seek a mandate from the Australian people to implement the Plan. Furthermore, consistent with the Government's previous commitments, the Commonwealth also reserves the right to proceed to a full funding takeover of the system in the future.

The Commonwealth looks forward to productive negotiations with states to deliver landmark reforms for health and hospitals.

CHAPTER 1: LISTENING TO THE COMMUNITY AND EXPERTS

This reform plan is the culmination of rigorous and serious engagement with health experts, practitioners, patients and the Australian community.

This plan builds on the final report of the National Health and Hospitals Reform Commission (NHHRC), established by the Government to conduct the most comprehensive review of Australia's health and hospital system in over 20 years. It also builds on the Government's extensive consultations on health reform with the Australian people across 2009 and 2010.

National Health and Hospitals Reform Commission

In addition to making immediate investments to tackle immediate priorities and key pressure points in the health system, the Government in 2008 set in train long term system-wide reform. The Government established the National Health and Hospitals Reform Commission (NHHRC) to conduct the most comprehensive structural review of Australia's health system in 20 years, and provide evidence-based advice on reform directions.

The NHHRC, chaired by Dr Christine Bennett, consisted of a panel of experts: Professor Justin Beilby, Dr Stephen Duckett, the Hon Dr Geoff Gallop AC, Dr Mukesh Haikerwal, Associate Professor Sabina Knight, the Hon Rob Knowles AO, Ms Mary Ann O'Loughlin, Professor Ronald Penny AO and Dr Sharon Wilcox.

The NHHRC's final report — released in July 2009 — included 123 recommendations for immediate and longer-term reforms of Australia's health system. The NHHRC emphasised the need to focus reforms on three main goals:

1. Tackling major access and equity issues that affect health outcomes for people now;
2. Redesigning our health system so that it is better positioned to respond to emerging challenges; and
3. Creating an agile and self-improving health system for long-term sustainability.

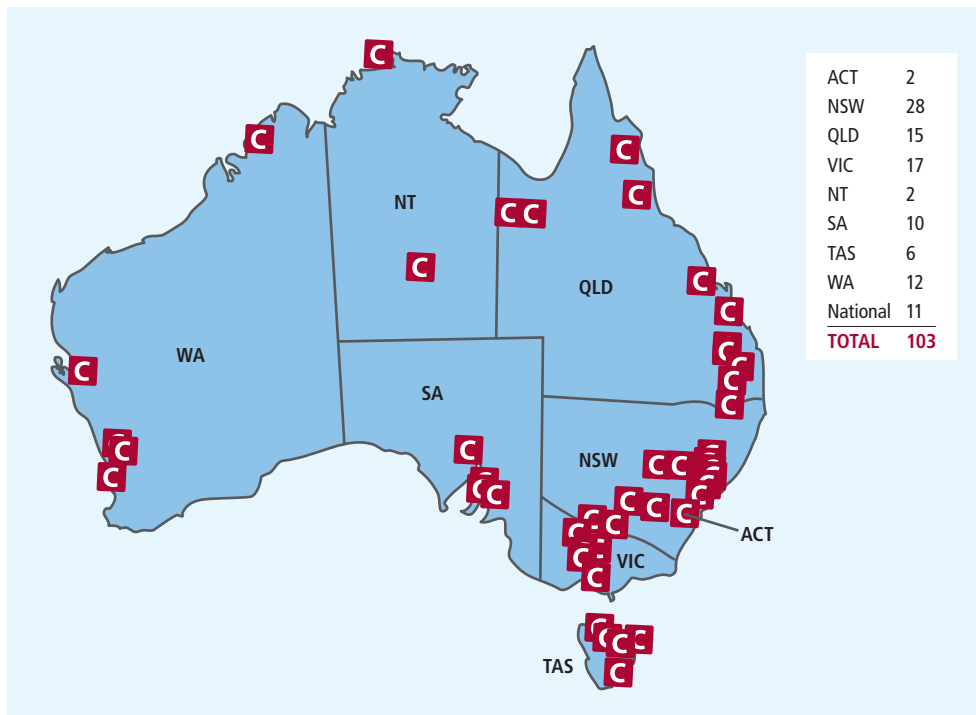
National Health and Hospitals Commission final report – key recommendations


- › An independent National Health Promotion and Prevention Agency
- › A personal electronic health record and national eHealth system
- › Commonwealth to assume responsibility for all primary health care policy and funding
- › Comprehensive Primary Health Care Centres
- › Voluntary enrolment for patients with chronic and complex conditions
- › Primary health care coordination through Primary Health Care Organisations
- › National Access Targets for timeliness of care
- › Hospital funding tied to performance
- › Introduction of activity based funding for all hospital services, with the Commonwealth paying a fixed percentage of the efficient price
- › Public reporting of public and private hospital performance
- › Range of measures related to choice in aged care
- › National Aboriginal and Torres Strait Islander Health Authority
- › Denticare
- › One-year dental internship program
- › A National Clinical Education and Training Agency
- › A permanent, independent and expanded Australian Commission on Safety and Quality in Health Care

Consultation with health professionals and the Australian people

Following the release of the NHHRC's report, the Government embarked on detailed consultation with health professionals and the Australian people on the report's recommendations. Across 2009 and 2010, the Prime Minister, the Health Minister, other Government Ministers and senior government officials conducted more than 100 consultations with patients, health professionals and the public. A website, *yourHealth.gov.au*, was established to allow all Australians to contribute their ideas, experiences and comments on the health system. More than 1,460 contributions have been posted to the *yourHealth* website and the site has had over 1 million visitors.

Figure 1: Locations of Government's health reform consultations





The Government has listened carefully to the expert advice and views put forward by the Australian community. Key feedback from consultations indicated a community desire for:

- › a stronger Commonwealth Government leadership role, coupled with higher standards and increased funding for public hospitals;
- › reduced health sector bureaucracy, simplified governance and accountability, and greater autonomy and flexibility at the local level;
- › better access to primary health care delivered by a team of health care professionals;
- › better public hospital services and waiting times;
- › better access to health care in rural Australia and disadvantaged areas; and
- › improved integration of information technology across our health system.

The Government also consulted with state and territory governments on the development of this Reform Plan through the Council of Australian Governments (COAG). At the COAG meeting in December 2009, the Commonwealth, states and territories agreed that long-term health reform is needed to deliver better services, more efficient and safer hospitals and more responsive primary health care.

2010 Intergenerational Report

Another source of expert input has been the 2010 Intergenerational Report. The future challenges outlined in the Intergenerational Report are a catalyst for many of the measures to improve the productivity and financial sustainability of the health system outlined in this Plan.

The 2010 Intergenerational Report projected that growth in all categories of Commonwealth health spending would increase, driven by population growth and ageing, increased demand for health services, and new technology. Commonwealth Government health spending is projected to grow from 4.0 per cent of GDP in 2009–10 to 7.1 per cent of GDP in 2049–50. The report forecasts that rising health costs will be by far the largest contributor to increased Commonwealth Government spending to 2050, accounting for around two-thirds of the overall increase in Commonwealth Government spending. This is consistent with and reinforces the conclusions of the previous two Intergenerational Reports, and provides further evidence that the ongoing sustainability of the system will be challenging.

CHAPTER 2: TAKING MAJORITY FUNDING RESPONSIBILITY FOR PUBLIC HOSPITALS

The Commonwealth Government will become the majority funder of the Australian public hospitals system.

The Government will fund:

- › 60 per cent of the efficient price of every public hospital service provided to public patients;
- › 60 per cent of recurrent expenditure on research and training functions undertaken in public hospitals;
- › 60 per cent of capital expenditure, both operating capital and planned new capital investment, to maintain and improve public hospital infrastructure; and
- › Over time, up to 100 per cent of the efficient price of 'primary health care equivalent' outpatient services provided to public hospital patients.

In return for providing a secure funding base for public hospitals into the future, the Commonwealth will require the states to commit to system wide reform to improve public hospital governance, performance and accountability.

A fragmented and blame ridden system

The Australian health system is hard to navigate for both patients and health professionals. It is characterised by eight different state and territory systems, with a variety of funding sources and funding boundaries that create incentives for cost-shifting between levels of government, fragmentation of patient care, and blame shifting. The final report of the NHHRC is one of many reports to identify this problem and its implications:

- › no one level of government has a detailed understanding of all aspects of the health system;
- › governments do not necessarily take account of the health system as a whole when formulating policy; and
- › governments can make decisions that have fiscal and other impacts extending well beyond their own programs.

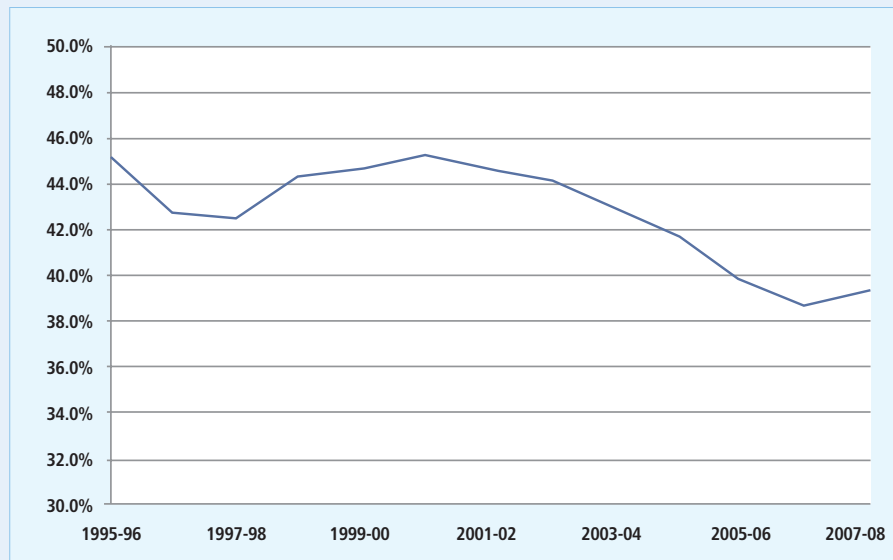
A number of the problems within the current system can be attributed to lack of transparency and cohesion, often arising from lack of clear financial leadership. This has resulted in blame shifting — an issue that has dominated debates on health for a number of years.

At its most basic level, blame shifting centres on the relative financial contribution of different levels of government. Debates over the relative funding shares of different levels of government surface most acutely in the context of negotiating hospital funding arrangements. These arrangements, through which the Commonwealth provides the states with indexed block grants for health and hospital funding, involve making projections about health volumes and prices over time, using historical data. For both levels of government — but above all for health professionals and those who rely on the health system — the stakes are high.

Box 1: Decreasing Commonwealth funding shares over time.


The Government's \$64 billion investment in health and hospitals through a new National Healthcare Specific Purpose Payment and National Partnerships with state and territory governments has temporarily reversed the trend of a declining Commonwealth share over the past decade. However current projections of continued strong growth in hospital demand, and increasing costs compared to the Commonwealth's funding contribution, could see the Commonwealth's funding share decline in the future.

Figure 2: Commonwealth proportional contribution to government funding for public hospitals



Source: Australian Institute of Health and Welfare, Health Expenditure Series Australia, 2007–08.

Includes expenditure through The Department of Veterans Affairs and through the Private Health Insurance Rebate.



In the last two decades, the most contentious issue arising from arrangements for hospital funding has been the slow decline over time of the Commonwealth's share of public hospital funding. In 1995–96, the Commonwealth's share of public hospital funding was over 45 per cent. By the final year of the previous Australian Health Care Agreements, it had declined to under 40 per cent, including expenditure through the Department of Veterans Affairs and through the Private Health Insurance rebate (see box 1 above). Current projections of continued strong growth in hospital demand, and increasing costs compared to the Commonwealth's funding contribution, could see the Commonwealth's funding share further decline into the future.

To complicate the situation, the efficient cost of providing different health services is not known in all parts of the country. This means it is unclear whether the Commonwealth's share of hospital funding has in part declined because of what may be growing inefficiencies in parts of the system (which in turn drive increases in state government spending). Measures the Government will take to improve the efficiency of public hospitals are discussed further in chapter seven.

Cost pressures and excess demand within parts of the health system have also fed cost shifting between different levels of government. For example, public hospital data suggest that admitted patient episodes for chemotherapy grew by about eight per cent between 1997–98 and 2005–06, whereas MBS-billed chemotherapy procedures rose by 183 per cent in the same period. Similarly, public inpatient separations for colonoscopies had grown by only 15 per cent, whereas MBS-billed procedures had risen by 86 per cent across the same period. This data may indicate cost-shifting, but may also illustrate an appropriate shift in clinical practice, through which patient care that has traditionally been provided in a hospital setting could safely be provided in alternative care settings. Poor funding of public hospital outpatient services may have contributed to these significant increases in MBS expenditure.

Similarly the states argue that inadequate Commonwealth funding of public hospitals and primary health care services over the long term has resulted in states facing increased public hospital costs, for example in emergency departments.



This cost shifting makes it very hard for Australians to tell which level of government is responsible for their health care, and to hold it accountable. Patients experience problems when the two parts of the system don't connect — for example, a patient who is discharged from hospital may not have a good discharge plan that supports their transition back to the care of a GP.

When systems fail, patients can end up back in hospital. Blame shifting is unproductive. The Commonwealth is committed to clarifying funding arrangements for public hospital services so that incentives for cost shifting and blame shifting are removed.

Box 2: 2008 National Healthcare Agreement

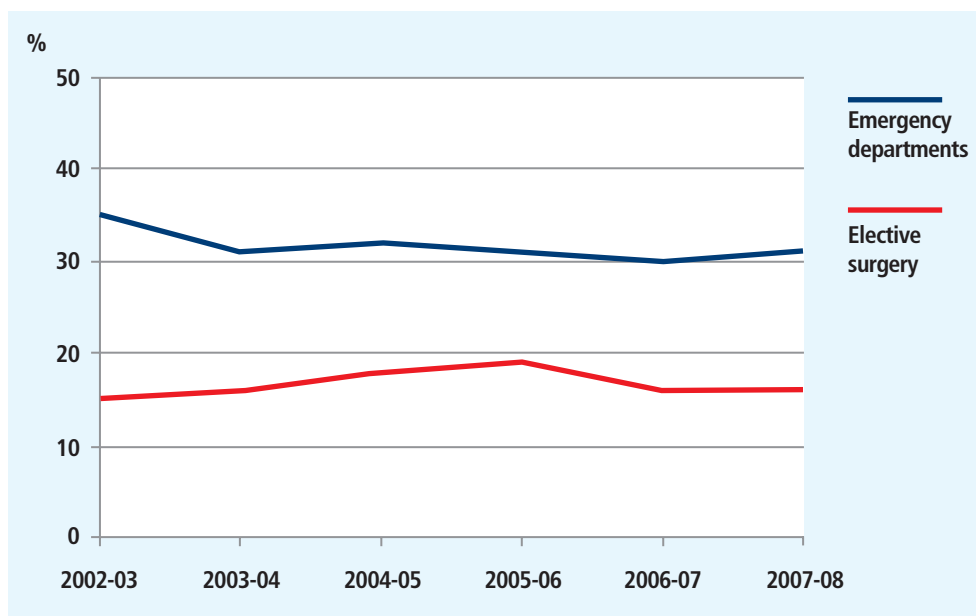
The 2008 National Healthcare Agreement (NHA) included funding of \$64 billion over five years, which reversed the cuts of the previous Agreement and provided \$4.8 billion in additional base funding. The Commonwealth provided a \$500 million recurrent boost in base funding in 2008–09, increasing the starting point for the NHA from \$10 billion to \$10.5 billion. The Commonwealth also delivered a more generous indexation formula, of around 7.3 per cent per annum, to put public hospital funding on a more sustainable footing. This included for the first time a health specific price index to better reflect the actual growth in health costs in the system. The NHA also improved transparency and accountability in the health and hospital system through agreement to a series of performance targets, outcomes and output measures.

Nevertheless there are still problems to be addressed. Roles and responsibilities are still unclear in the health system, leading to inefficiency and blame shifting. Health costs are still rising faster than Commonwealth indexation.

Long waiting times and pressure on hospitals and health professionals

Blame-shifting and cost-shifting contribute to increasing pressure on our public hospitals. Major symptoms of this pressure are long waiting times for elective surgery and emergency department services. One in six elective surgery patients and one in three people attending emergency departments wait longer than the recommended time for treatment. Figure 3 demonstrates that these levels have been stable over the last five years, suggesting little progress has been made in improving waiting times. Clearly, changes are needed to create additional capacity in the system to meet growing demand.

Figure 3: Hospital patients not seen within clinically recommended times



Source: Commonwealth Department of Health and Ageing, *The state of our public hospitals*, 2009.

Increasing pressure on hospitals also has real consequences for patient safety and quality of care. The NHHRC reported that adverse events causing harm to patients in health care are conservatively estimated to cost the Australian health system more than \$2 billion each year. Further inefficiencies, such as duplicate testing and potentially preventable hospitalisations, also generate a significant cost to the system.

The Commonwealth as the majority funder

To overcome fragmentation, blame shifting and cost shifting across the health system, the Commonwealth will move to ensure that one level of government has majority funding responsibility for the hospital system.


In a fundamental change to hospital funding arrangements, the Commonwealth will increase its funding contribution for public hospital services to:

- › 60 per cent of the efficient price of every public hospital service provided to public patients;
- › 60 per cent of recurrent expenditure on research and training functions undertaken in public hospitals;
- › 60 per cent of capital expenditure, both operating capital and planned new capital investment, to maintain and improve public hospital infrastructure; and
- › over time, up to 100 per cent of the efficient price of 'primary health care equivalent' outpatient services provided to public hospital patients.

By becoming the majority funder of public hospital services and fixing its funding share based on an independently determined efficient price of service, the Commonwealth Government is acting consistently with one of the key recommendations of the NHHRC report: namely, that the Commonwealth should increase its funding share to 100 per cent of the efficient cost of outpatient services, and 40 per cent of the efficient cost of acute and sub-acute care for public patients.

The Commonwealth will assume greater financial responsibility by progressively moving from payment for public hospital services on the basis of recurrent expenditure to payment on the basis of a national efficient price for each hospital service. An independent umpire at arm's length from Commonwealth and state governments will set the nationally efficient price, and in doing so, will strike an appropriate balance between the sustainability of the hospital system, reasonable levels of access, clinical safety, efficiency, and the significant fiscal impact that hospital funding will have for both the Commonwealth and the states.

The nationally efficient price will cover both the recurrent costs of patient services and the operating capital required to deliver those services. Chapter seven outlines the implementation stages for payment against actual services delivered. The independent umpire will also be given authority to make binding determinations on boundary issues between the Commonwealth and the states, so that cost shifting becomes a practice of the past.



Under these new funding arrangements, the Commonwealth will meet its share of the efficient price of all public hospital services that Local Hospital Networks provide. Blame shifting over declining shares, base funding and indexation rates will be replaced with a stable, secure funding base, with one level of government driving funding arrangements.

The Commonwealth will meet 60 per cent of the efficient price of every emergency department and admitted patient service delivered by a public hospital to a public patient.

The Government will also fund 60 per cent of the efficient cost of outpatient services. The Commonwealth will work with the states to move to fund 100 per cent of the efficient price of those outpatient services that are better characterised as primary health care services.

The Government has decided to fund outpatients in this way, as opposed to 100 per cent of all outpatient services as recommended by the NHHRC, in light of the views expressed in public consultations across the country. The consultations highlighted that outpatient services are not all the same and vary substantially from one specialisation to another. Some outpatient services are more closely associated with admitted services, whereas others can be more appropriately associated with primary health care.

With the assistance of the states, and the increased data that will become available as a result of these reforms, the Government aims to distinguish between these different types of outpatient services, and over time, move to funding them in a manner that better reflects the character of the service. In doing this, the Government will ensure patients continue to receive care free of charge in public hospitals.

Funding for research and training

Funding pressures in public hospitals have often resulted in limited funding for non-patient services such as research and training, which are essential to building the specialist workforce for the future and retaining expertise within the public hospital system. The Commonwealth will pay 60 per cent of recurrent expenditure on research and training functions undertaken in public hospitals.

Funding for capital expenditure

State governments are currently responsible for meeting the full cost of major capital investments in public hospital infrastructure. With the Commonwealth making a greater investment in recurrent public hospital services, the Government faces strong incentives to ensure that public hospitals have appropriate facilities and equipment to ensure that they can continue to provide services efficiently.

The Commonwealth will make a funding contribution towards the costs of operating capital (such as equipment essential for delivery of services to patients) as part of the independent assessment of the efficient price to be paid for each service.

In addition, the Commonwealth will commit to fund 60 per cent of planned new capital investment through a mechanism to be negotiated with states. States will continue to decide where hospitals are located, and manage capital planning arrangements for public hospital services.

The role of states and territories

In return for providing a secure funding base for public hospitals into the future, the Commonwealth will require the states to commit to system wide reform to improve public hospital governance, performance and accountability.

States will continue to be responsible for meeting the remaining costs of public hospital services, including meeting any costs over and above the efficient price, as well as the remainder of teaching, research and capital costs. This creates a strong incentive for states to be as efficient as possible in playing their ongoing role in our public hospital system.

State governments will also continue to own public hospital assets. They will work with Local Hospital Networks to determine the range and number of public hospital services to be provided within their jurisdiction, and to be responsible for all aspects of industrial relations policy and employment of the public hospital workforce. States will also continue to have responsibility for the delivery of essential health-related services such as ambulance and patient-assisted travel schemes.

How the Government will implement this reform

Over 2010–11, the Commonwealth will work with the states to determine the current and future costs of delivering public hospital services to calibrate the financial transfers required.

From 1 July 2011, the Commonwealth will increase its funding contribution to 60 per cent of recurrent expenditure on public hospital services, research and training, and planned new capital expenditure.

From 1 July 2012, the Commonwealth will progressively shift this funding to activity based funding paid directly to Local Hospital Networks, starting with admitted patient services and progressing to emergency department and outpatient services.

The Commonwealth will consult with the states on the mechanisms to give effect to its commitment to fund 60 per cent of planned new capital investment.

CHAPTER 3: TAKING FULL FUNDING AND POLICY RESPONSIBILITY FOR GP AND PRIMARY HEALTH CARE

The Commonwealth Government will take full responsibility for funding all general practice and primary health care services in Australia.

Over time, the Government will also move to fully fund up to 100 per cent of those hospital outpatient services that are better characterised as primary health care.

These reforms will provide a platform for providing better care in the community, to keep people healthy and take pressure off hospital services.

Pressure on hospitals from poorly integrated primary health care

GP and primary health care is the frontline of Australia's health system. More than 85 per cent of Australians see a GP at least once a year. Medicare subsidises more than 110 million visits to GPs each year.

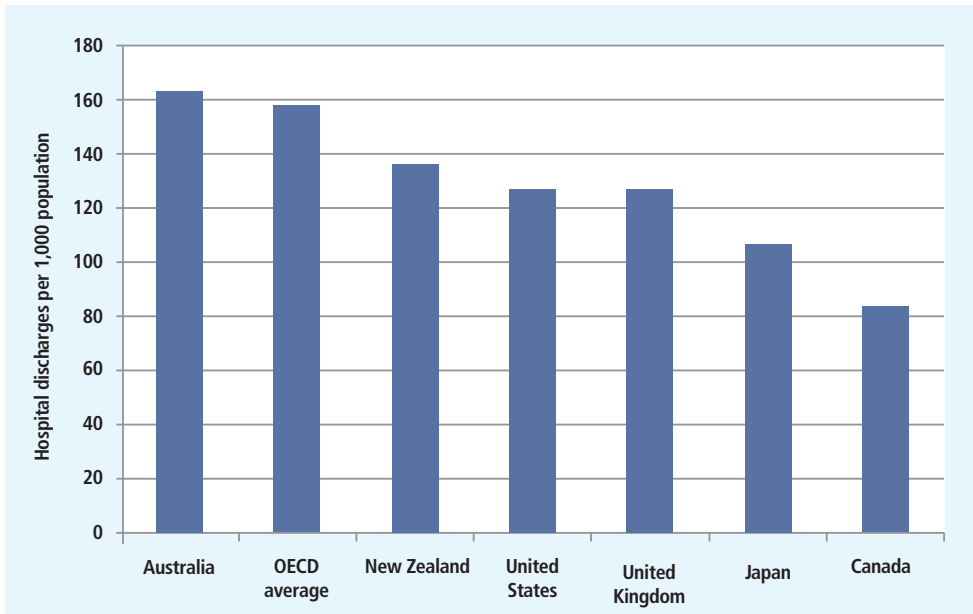
While Australia's GPs and other primary health care professionals serve the community well, they could be better supported to meet the health care needs of our growing and ageing population, in particular the increasing burden of chronic disease. Chronic disease already accounts for more than 80 per cent of the burden of disease suffered by Australians.

Because there is not always adequate access to GPs and primary health care, many patients with chronic and complex conditions end up in hospital, when this could have been avoided had they received better care in the community. As well as involving unnecessary ill-health and distress for patients, these potentially preventable hospitalisations clog up the health system and are very costly.

The Australian Institute of Health and Welfare has estimated that potentially preventable hospitalisations represented 9.3 per cent of all hospitalisations in 2007–08. This equates to approximately 441,000 hospitalisations in public hospitals, with an average cost of about \$4,230 per episode of care.

Australia has very high hospitalisation rates compared to the OECD average and countries such as the United States, Canada and New Zealand, as shown in figure four.

Figure 4: Hospital discharges per 1,000 population, selected countries, 2007



Source: Organisation for Economic Cooperation and Development, *Health at a Glance 2009*.

Increasingly, both in Australia and overseas, it is recognised that strengthening and improving the way in which primary health care is provided is vital in determining how well the health system responds to current and emerging pressures.

Research shows that those health systems with strong primary health care are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes including lower mortality.

The draft National Primary Care Strategy, released in July 2009, refers to a recently released World Health Organization (WHO) Report, 'Primary Health Care: now more than ever'. The WHO Report found that, in comparing countries at the same level of economic development, those that are organised around the tenets of primary health care produce better health outcomes for their populations than those that are not.



Since coming to office in 2007 the Government has enhanced GP and primary health care through:

- › funding for 36 GP Super Clinics that are being built across the country to provide comprehensive services bringing together GPs, nurses, visiting medical specialists, allied health professionals and other health care providers;
- › increasing GP training places by 35 per cent, to more than 800 places each year; and
- › developing Australia's first *National Primary Health Care Strategy*.

A patchwork system of GP and primary health care


Primary health care in Australia is characterised by complex, fragmented and often uncoordinated delivery systems. Primary health care is currently provided by:

- › private providers such as GPs and allied health professionals;
- › state funded community health centres; and
- › outpatient clinics and emergency departments.

Primary health care delivery is still largely based on the provision of episodic care by a GP. Increasing rates of chronic disease, together with an ageing population, mean that an increasing number of patients require greater levels of support and care to be provided in a more integrated and accessible fashion.

At the same time, the nature of treatment provided in acute care has changed, with patients being discharged earlier and some conditions now predominantly managed by primary health care professionals in the community. The fragmented provision of care, both in the acute and primary health care settings, results in some patients failing to receive the care they need. This creates additional pressure on public hospitals, as demonstrated by the number of potentially preventable admissions to hospitals.

Submissions to the *National Primary Health Care Strategy*, especially from consumer groups, consistently stressed the need for better integration of primary health care services. In a similar vein the report of the NHHRC noted that primary health care is the foundation of the health system and needs clearer direction and better integration into the system as a whole. Bringing the entire primary health care sector under one level of government is the first step in better integrating these disparate services in order to meet the current and future needs of Australian patients.



Currently, the Commonwealth and state governments share responsibility for primary health care services. In total, \$4.8 billion was paid in subsidies for Medicare-funded GP, practice nurse and allied health services in 2007–08. State and local governments spent \$4.3 billion on ‘community health and other’ care in 2007–08.

States provide a range of services, including community health centres, allied health, child and maternal health clinics, drug and alcohol, and community mental health services. Over the last decade, some state governments have also chosen to play a more direct role in primary health care — as a means of reducing demand on their hospitals.

Many of these services are funded by state governments directly, but are often supplemented by grants or other kinds of funding from the Commonwealth. Some services provided in state-funded community health settings are equivalent to MBS services, while others are closely linked to acute services performed in hospitals.

Primary health care nursing is an example of where there is risk of duplication of services. Nurses in general practice and community nursing services are currently funded by two levels of government and operate from different premises, even though they are often seeing the same patients.

Over time, this complex set of funding arrangements for GP and primary health care has resulted in duplication of effort by both the Commonwealth and state governments in some areas, and has created gaps in delivery in others. Multiple and fragmented funding streams mean that service delivery arrangements can be inflexible and poorly coordinated, both within primary health care but also across hospitals, aged care and specialist care.

The reforms outlined in this document will provide a platform for better integrating the current patchwork of GP and primary health care services.

Taking funding and policy responsibility for primary health care across Australia

A single government funder of primary health care will reduce cost shifting and blame shifting, allowing the current duplication of services to be minimised.

The NHHRC recommended this change in order to:

- › create an integrated and comprehensive platform of services, bringing together privately funded GP services with state-funded community health services;
- › promote continuity and better coordinated care across all health professionals; and
- › position the health system to be better able to respond to the growing burden of chronic disease.

The NHHRC recommended that the Commonwealth take policy and funding responsibility for the Home and Community Care program and for all state-funded health care currently provided in the community, including child and maternal health services, drug and alcohol services, and community mental health services.


The detail of what is “in scope” for transfer to the Commonwealth in particular states will be negotiated with the states over the coming months.

Moving to fund up to 100 per cent of the efficient cost of ‘primary health care equivalent’ outpatient services

In addition to taking full policy and funding responsibility for primary health care, the Commonwealth will also move over time to funding a greater share of those outpatient services that are better characterised as primary health care equivalent services, as outlined in chapter two.

Currently a wide range of outpatient services are delivered in hospitals. Some, like post-operative services, are closely linked to other hospital services. Some require skills and infrastructure primarily available in hospitals — for instance diagnostic procedures requiring MRI technology.

Other outpatient services are better thought of as part of the primary health care system, and could be provided as effectively and potentially more efficiently in a community setting — for instance physiotherapy. Some of these outpatient services are provided in different settings in different states, often based on financial reasons rather than decisions around the most appropriate care for the patient. For example chemotherapy is provided on an outpatient basis in some states, and as an inpatient service in others.



There are clear opportunities to reform outpatient funding and service delivery, to set clear boundaries between services types in order to reduce cost-shifting. Reforms would also ensure patients in different states are entitled to the same standard of care, and may result, over time, in some services moving to community settings that are more convenient for patients and more cost effective.

The NHHRC recommended the Commonwealth move to fund 100 per cent of outpatient services. However, there is currently no data that would allow clear boundaries to be drawn between outpatient services that need to be provided in public hospitals, and primary health care equivalent outpatient services that could be provided in the community.

Consequently, the Commonwealth Government will initially fund all current outpatient services at 60 per cent of recurrent expenditure, in line with other public hospital services. The Government will work to distinguish between 'primary health care equivalent' and hospital based outpatient services, moving over time to pay up to 100 per cent of the efficient price of 'primary health care equivalent' services. This will establish a more efficient outpatient funding model that will improve care quality, and provide greater convenience for patients. It will make the Commonwealth Government financially responsible for ensuring that patients who do not need to visit a hospital can receive treatment in more convenient and less costly locations, and will remove a major opportunity for cost-shifting.

States will be required to fund those services that are not 'primary health care equivalent' consistently with all other services provided by public hospitals. As with all other public hospital services, the Commonwealth Government will fund 60 per cent of the efficient price of these services.

The importance of this reform is that by taking funding and policy responsibility for all primary health care services, and 60 per cent of public hospital funding, the Commonwealth will have the ability to drive 'allocative efficiency' across the system. This will encourage integrated care and ensure patients are cared for in the most appropriate and efficient setting.

Box 3: Allocative efficiency

Allocative efficiency is about ensuring that available resources are allocated to their most effective purpose in the health system. Clarification of roles and responsibilities will increase allocative efficiency by allowing the Commonwealth to better spread resources across the primary health care system. The Commonwealth will have an incentive to ensure the delivery of effective primary health care to keep people out of hospital.

Integrating primary health care is an essential preparatory step to further Commonwealth Government primary health care reforms. As part of its commitment to a comprehensive reform plan, the Government will announce further reform to governance of primary health care in order to give effect to improved integration of services, and provide the basis for other reforms to improve access to services, increase the efficiency of primary health care, and deliver care for patients with chronic disease that is tailored to managing their condition and keeping them healthy over time. Changes to funding arrangements for outpatient care will further strengthen the delivery of care in the community and ensure that patients receive services in an appropriate setting.

What this reform will mean in practice

Over time, these reforms will mean that the type of care currently available through GP Super Clinics and similar practices will be more available to patients on a more consistent basis across the country. This will either be in the one physical location, as with the Super Clinics, or through “virtual clinics” with better integration of the predominantly state funded allied health workers with GPs.

Where these arrangements are already in place, such as with South Australia’s GP Plus health care centres, states may continue to operate these services with funding provided by the Commonwealth. The Commonwealth will take funding and policy responsibility, but services will continue to be provided by a wide range of providers including the private sector, community organisations, local councils and state governments. MBS arrangements that underpin privately practising GPs will remain in place.



How the Government will implement this reform

As a first step, the Commonwealth will work with the states to conduct a stocktake of primary health care services. This will identify and cost the services to be directly funded by the Commonwealth.

From 2011–12, the Commonwealth will commence funding those primary health care programs currently funded and provided by the states. Some states have developed successful models of care, and the Commonwealth will build on these models and share them more quickly around the country, so Australians in all states can benefit from successful innovations.

In the medium term, some states may wish to continue to operate services while others may prefer to divest operational control. These issues will be explored in negotiations. An overriding principle will be to minimise disruption to patients and staff.

CHAPTER 4: REBALANCING FINANCIAL RESPONSIBILITY IN THE FEDERATION

The Commonwealth Government will take responsibility for an increased share of health care costs by increasing its contribution to public hospital services and taking over primary health care funding.

It will finance these changes by dedicating around one-third of total GST revenue — all of which is currently provided to the states — directly to health and hospital services across the country.

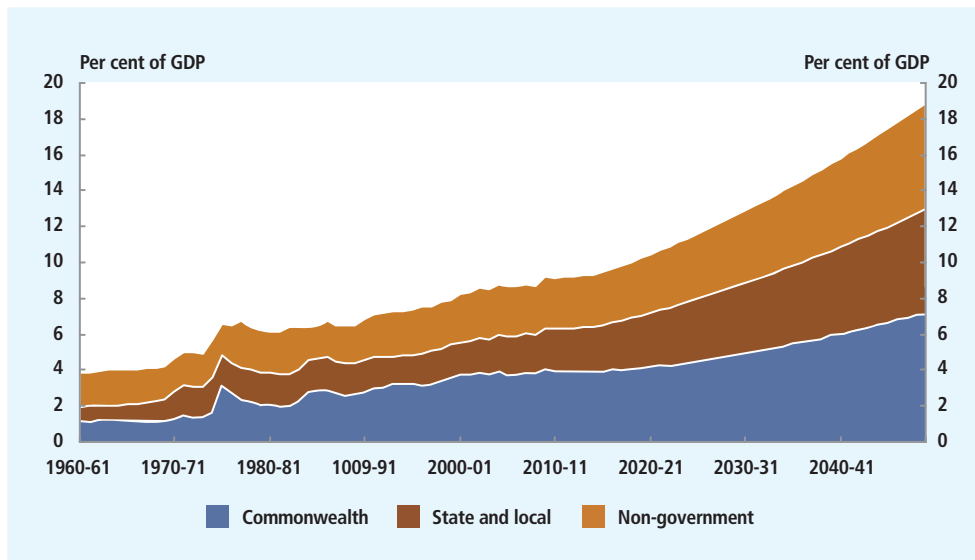
This plan is fully funded over the upcoming forward estimates. These changes will be delivered consistently with the Government's fiscal rules.

A health system under financial pressure

The cost of health care has risen significantly in past decades and will continue to rise into the future. Health costs are projected to increase from 15 per cent of all Commonwealth Government spending now (4.0 per cent of GDP) to 26 per cent by 2050 (7.1 per cent of GDP) — an increase in 2049–50 of around \$200 billion from today's spending. The 2010 Intergenerational Report shows that health spending is one of the Commonwealth's fastest growing spending pressures, and contributes to around two-thirds of the total increase in Commonwealth Government spending over this period.

As the population ages and grows, more people will fall into the older age groups that are the most frequent users of the public health system. In addition to demographic pressures, demand for higher standards of care will place pressure on the Government to increase expenditure, as will rapid technological innovation.

Figure 5: Projected health expenditure by source of funds

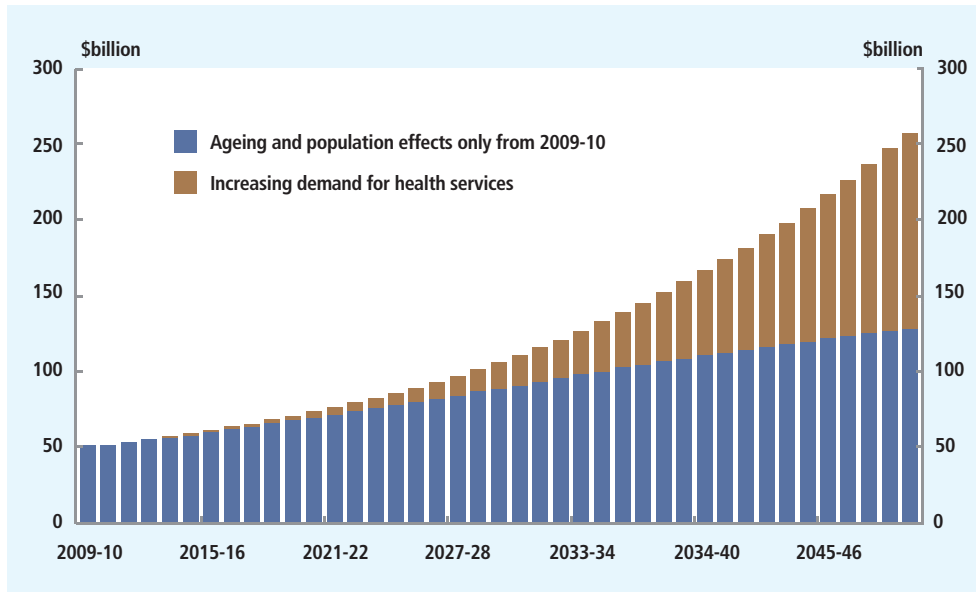


Source: Treasury projections based on data from the Australian Institute of Health and Welfare. Based on current arrangements.

An ageing population

The 2010 Intergenerational Report shows that the proportion of our population aged over 65 is forecast to increase from 14 per cent in 2010 to 23 per cent by 2050, with those aged over 85 reaching 5.1 per cent of the population by 2050. This will lead to an increased number of people requiring services and treatment to help with dementia, mobility, hearing, eyesight and general frailty. Meeting these needs will require not only additional services, but larger health budgets. Per capita health spending on the aged is four times higher than health spending on people under 65. From 2009–10 to 2049–50, real health spending on those aged over 65 years is expected to increase around seven-fold, and around twelve-fold for those over 85 years.

Figure 6: Projected Australian Government health spending



Source: Treasury projections. Based on current arrangements.

A growing population

Population growth will create further pressures on our health system. Our population is projected to grow from 22 million today to 36 million by 2050. This will further increase the need for more health services, as well as new care facilities and an expanded health workforce.

Financial and workforce constraints increase the challenge of providing new health care facilities. They increase the challenge of attracting and training the workforce to deliver the health services to meet the needs of our growing population. That is why it is critical that reforms raise the productivity of the health sector. A more productive health sector will meet the challenges of providing high quality and accessible services to a growing population.

Increasing cost of care

The costs of providing health care have increased sharply in recent years, in part due to the growing role expensive new technologies and pharmaceuticals play in health care. Significant increases in labour costs, as well as increasing patient expectations of the health system, are also impacting on health care costs. Health spending was 45 per cent more in 2005–06 than a decade before, even after adjusting for inflation. Many of these cost pressures come about because too many people end up in hospital in circumstances where better quality care in the community would have treated their condition and kept them out of hospital. As well as involving unnecessary ill-health and distress for patients, these potentially preventable hospitalisations clog up the health system and are very costly.

The Government has taken a number of tough decisions to rein in growing health pressures. The Government's proposed changes to the Private Health Insurance Rebate manage the fastest growing pressure on health expenditure, and ensure health spending is targeting those most in need.

Spending on the Private Health Insurance Rebate has grown from \$2.1 billion in 2000–01 (the first full year of operation) to \$4.2 billion last financial year. Real spending per person is projected to increase by more than 50 per cent from 2012–13 to 2022–23 to the equivalent of \$319 per person in 2022–23.

The Government's changes to the Private Health Insurance Rebate have been designed to have a minimal impact on participation, with private health insurance coverage remaining at 99.7 per cent of existing levels, according to Treasury analysis.

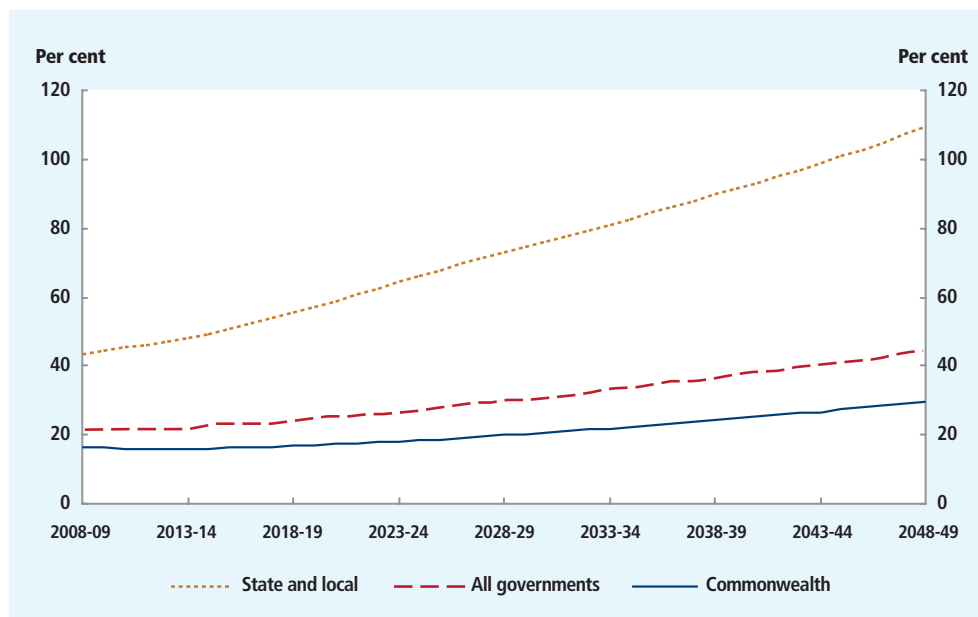
The Government has also delivered changes to the Extended Medicare Safety Net (saving \$436 million over four years) and the Medicare Levy Surcharge thresholds (delivering a net saving of \$380 million over four years) in the last two Budgets. Measures like these are critical to ensuring our nation's health system is sustainable and delivering value for money.

States' capacity to meet these costs


On the basis of current spending and revenue trends, there is a real risk that state governments will not have the financial capacity to meet health spending obligations in the longer term, placing our health system and services at risk.

In the five years to 2007–08, public hospital expenditure has grown at an average of close to ten per cent per year. As shown in figure seven below, if current spending and revenue trends continue, the Treasury projects that health spending alone would absorb more than the entire revenue collected by all states by 2045–46 — and earlier in some states.

Figure 7: Health funding responsibility as a proportion of own-source tax revenue (illustrative)



Source: Treasury projections based on data from the Australian Institute of Health and Welfare. Tax held constant as a share of GDP. Based on current arrangements.



Part of the answer to this challenge will lie in achieving greater system wide efficiencies — these are central to this reform plan. Productivity gains will require more efficient allocation of funding along with more efficient operation of the health system. Under the Government’s proposed reforms, these gains will be driven by better clarification of roles and responsibilities (see chapters two and three), national standards with improved accountability for performance (chapter five), the decentralisation of hospital management (chapter 6) and the introduction of activity based funding (chapter seven). Productivity gains will allow a given funding level to deliver more services, and for those services to be higher quality. For example, the NHHRC estimated that the introduction of activity based funding alone could yield system-wide savings of between \$0.5 billion and \$1.3 billion a year (in 2006–07 dollars).

However, fundamental reform of federal financial relations is also necessary if we are to address the challenge of growing health care costs and to prevent the health system from buckling under its own weight. This reform will provide a secure funding base for public hospital services into the future.

Commonwealth taking financial responsibility

The Commonwealth will dedicate around one-third of total GST allocations to fixing its funding contribution for public hospital services at 60 per cent of the efficient price, and assuming full funding responsibility for primary health care funding. These funds — in the order of \$90 billion over the first five years of the new arrangements — will be dedicated to health and hospital spending, invested through a new National Hospitals Fund that will be clearly identified and detailed in Commonwealth budget papers.

The Commonwealth’s increased funding share will also draw on the funds currently paid through the health care Specific Purpose Payment.

These new arrangements represent a fundamental reform of federal financial relations. They will help underwrite the sustainability of the health system, better balance fiscal responsibilities across the federation and lead to economy-wide efficiencies.

As part of these new arrangements, the Commonwealth will be responsible for a substantially increased share of the expected growth in health care costs over time, above and beyond the value of the GST it will retain. Instead of paying its current minority share of every dollar of growth in the hospital system, the Commonwealth will now pay 60 per cent of the efficient cost of every public hospital service provided to public patients, with transition to this arrangement over time.

Box 4: GST distribution under the new health and hospital financing arrangements

The proportion of GST dedicated to health care will gradually grow over the upcoming forward estimates, and then be fixed over time from 2013–14. This means this reform is expected to be revenue neutral to the states and the Commonwealth over the upcoming forward estimates, and that all states will benefit from this reform over the longer term.

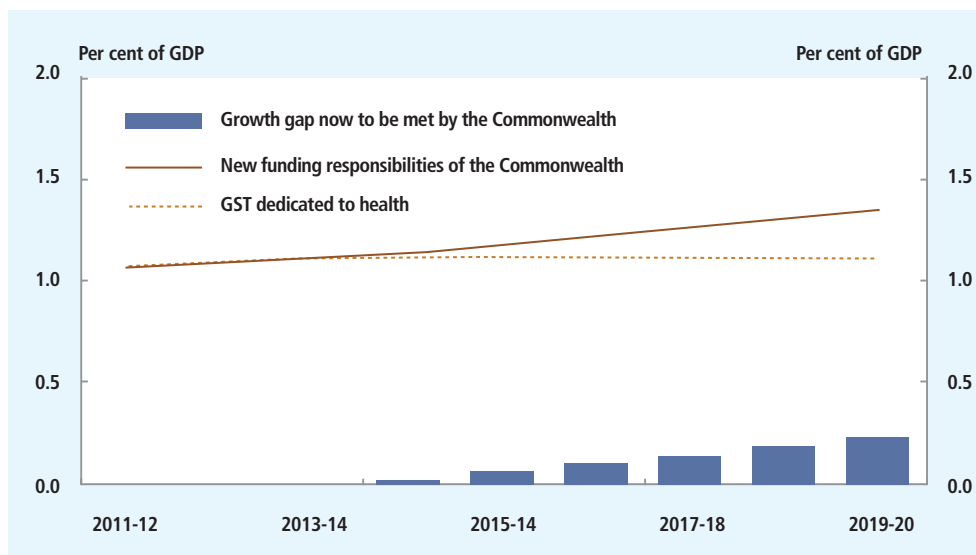
Over the upcoming forward estimates, the amount of GST a state receives that is dedicated to health care will be determined by the amount needed to bring Commonwealth funding to 60 per cent of expected hospital costs, and 100 per cent of primary health care costs. The remainder of the GST will be general revenue assistance. The proportion of the GST dedicated to health for each state will vary between the states although, in aggregate, around one third of the GST pool will be dedicated to health care nationally. Final arrangements on this matter will be discussed with the states.

The total GST pool (including GST payments dedicated to health care) will continue to be distributed across the states in accordance with relativities recommended by the Commonwealth Grants Commission.

This change represents a significant shift in financial responsibilities across the federation, not least because hospital costs have been growing at close to ten per cent per annum, and are expected to continue to outpace growth in GST of around six per cent per annum over the medium term. The Commonwealth's enhanced funding responsibility will commence as the foundations of a new health and hospital system — particularly reformed roles and responsibilities, national standards, activity based funding, and local management of hospital services — are established.

Part of the answer to the challenge of funding growing health care costs over time will be in eliminating waste and duplication. This is a core component of the Government's health reform plan. Reforms to take over full funding and policy responsibility for primary care, and the introduction of Local Hospital Networks, will increase allocative efficiency across the system. The introduction of activity based funding will drive operational efficiency — making sure the system is characterised by less waste and more output for a given level of public expenditure.

Figure 8: Taking on a share of increasing state and territory expenditure



Source: Treasury projection. Based on current arrangements.

More efficient and sustainable financing of the health system

The Commonwealth Government will take a greater share of funding for our nation’s health system, securing the funding base for health and hospital services into the future. This will reduce the reliance on less efficient state taxes to finance health services.

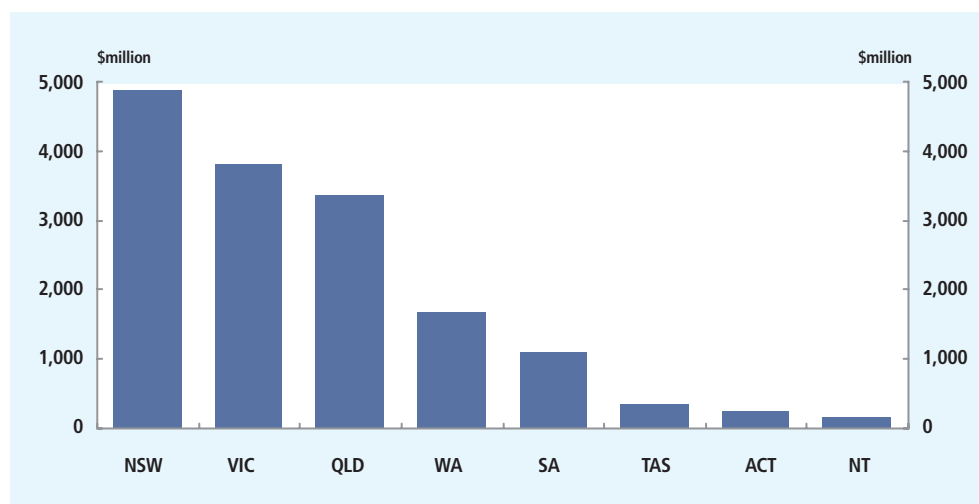
The Commonwealth Government is better placed to take responsibility for the future growth across health and hospitals, due to its stronger budget position, characterised by revenue sources that are better able to handle fiscal adjustment over time.

These reforms will reduce future pressure on the states to raise more revenue to finance health services through their less efficient taxes. This will yield productivity dividends across the national economy. These changes will also lead to better alignment between spending responsibilities and revenue-raising capacity in both Commonwealth and state governments.

This reform will provide states with greater capacity to deliver on other critical state government responsibilities, including schools, public transport and roads. In aggregate, as shown in the figure below, over the period between 2014–15 and 2019–20 the projected benefit to the states and territories is in the order of \$15 billion. This represents a major contribution by the Commonwealth, placing our health system on a more sustainable footing, and relieving states of medium and longer-term financing responsibilities. The Commonwealth contribution will grow over time.

The difference in gains for each state reflects their different population sizes and associated health costs into the future.

Figure 9: Expected improvement in budgetary position on a population share basis (by state, 2014–15 to 2019–20)



Source: Treasury projection. Based on current arrangements.

Fiscally responsible reform

This plan is fully funded over the upcoming forward estimates through to 2013–14. These changes will be delivered consistently with the Government’s fiscal rules.

Box 5: Meeting the Government’s medium term fiscal strategy

This reform is consistent with the Government’s fiscal strategy — fully funded over the upcoming forward estimates and consistent with returning the Budget to surplus by 2015–16, while keeping the share of taxation to GDP on average below 2007–08 levels. Fiscal sustainability will be delivered through the Government’s commitment to ensure that real growth in spending is constrained to 2 per cent once the economy returns to above trend growth and until the Budget returns to surplus.

The Government’s path back to surplus will remain on course, as will its repayment of net debt, with net debt returning to zero consistent with the Government’s medium-term plans.

The Government has already delivered \$56 billion in savings in the 2008–09 and 2009–10 Budgets. The Government is prepared to make further difficult decisions in order to ensure the long term sustainability of the health system and the delivery of the fiscal strategy.

The Government recognises that additional investments will be required over time to meet increased demands on the health system. Any additional investment in our health system will be consistent with the Government’s fiscal strategy. The Commonwealth Government has already undertaken significant reforms in order to place health costs on a more sustainable footing.

The Government is prepared to make further structural changes to finance a more sustainable, efficient and high quality health system for all Australians. These reforms will help build a stronger health system and improve federal financial relations, while maintaining economic responsibility.

How the Government will implement this reform

From 1 July 2011, payments will be made to the state governments to provide to hospitals, and Local Hospital Networks where they have been established. These payments will include the current healthcare Specific Purpose Payment (SPP) and sufficient dedicated GST revenue to meet 60 per cent of expenditure on health costs in each jurisdiction, with the share of GST revenue retained for health growing as required to meet the growth in hospitals expenditure.

From 1 July 2012, the Commonwealth will move to directly paying the Local Hospital Networks a 60 per cent contribution of all health care costs, distributed on the basis of services delivered in each Local Hospital Network. Funding will again be drawn from the current SPP and dedicated GST revenue.

From 1 July 2013, the share of GST revenue to be dedicated to health care costs will be fixed. The Commonwealth's contribution to future growth in health costs, over and above the rate of growth in GST, will be met from its budget. Funding to Local Hospital Networks will move from an individual state price towards a national efficient price.

The Commonwealth intends to work with the states to ensure that the transition to the new arrangements is as smooth as possible. In particular, the Commonwealth will work with the states, the independent hospital pricing function, and the Commonwealth Grants Commission (CGC) to ensure an appropriate interaction between the new payment arrangements, the introduction of activity based funding, and the operation of the CGC's redistribution (horizontal fiscal equalisation) processes.

In finalising arrangements with the states, the Commonwealth will ensure that states maintain appropriate levels of health expenditure (including hospital capital investment) through until the end of 2013-14 when the share of GST dedicated to health will be fixed.

CHAPTER 5: NATIONAL STANDARDS FOR A UNIFIED HEALTH SYSTEM

The Commonwealth will require strong national standards and transparent reporting in the health system.

For the first time, Australians will be able to access transparent and nationally comparable performance data and information on hospitals and health services — including emergency department and elective surgery waiting times, bed occupancy rates and reporting of adverse events and hospital acquired infections.

Eight state and territory systems


Information on individual health and hospital services available today can vary substantially from state to state. While most states report information on their individual public hospitals in annual or quarterly reports that are published on state government health department websites, nationally comparable data is limited.

The November 2008 COAG agreement was the first step towards rectifying the lack of transparency over health and hospital services in Australia. For the first time, all Australian Governments agreed that there would be health system wide reporting — including the Commonwealth reporting on primary health care indicators.

A lack of transparency for a significant taxpayer investment — particularly at individual hospital level

Although around \$70 billion in taxpayer funding was spent on health and hospitals over the last year, there is little nationally consistent and comparable information available on the performance outcomes of individual health and hospital services. Patients and the Australian community do not have sufficient information about the performance of their local hospitals, general practitioners and other health care providers in the system.

While a substantial amount of system and government-level information is available, less information is published about local health services, how they are delivered and how they perform.



A lack of access to individual hospital level data was also highlighted in the Productivity Commission's recent report into public and private hospitals, which argued that 'long-term improvements to health outcomes need comprehensive public reporting of quality and patient safety by all hospitals.... Hospitals vary significantly, and reporting broad statistics masks the major variation that can occur between hospitals, as observed by the Australian Commission on Safety and Quality in Health Care. It is hospital-level data, not jurisdictional, that health care consumers, providers, funders (private health insurers and governments), regulators and policy makers need to inform their decisions.'

The NHHRC also pointed out that no level of government currently formulates policies that take into account the health system as whole, and recommended that:

- › systems be put in place to provide comparative clinical performance data back to health services and hospitals, clinical units and clinicians;
- › the Australian Commission on Safety and Quality in Health Care should analyse and report on safety and quality across all health settings, and that this also include patient experience surveys and patient-reported outcomes measures;
- › hospitals, primary health care centres, and residential aged care services publicly report on how they are progressing with quality improvement activities and research; and
- › there should be regular reporting that tracks progress in tackling health inequity.

Setting national standards to deliver a nationally unified system

The Commonwealth Government will use its position as the majority funder of health and hospital services in Australia to impose strong national standards for health care and build a nationally unified health system. These national standards will clearly state the high expectations all Australians can have of their health and hospital services.

A particular area of concern and variability in the performance of the eight states and territories has been access to emergency departments and elective surgery. As part of its national leadership role, the Commonwealth will increasingly look to insist on higher national standards of performance, more consistently applied across the country, with new targets backed up by explicit financial rewards and penalties.



Other areas in which national standards will be developed include:

- › access to local GPs and other health professionals;
- › financial performance and efficiency; and
- › safety and quality — such as reporting of adverse events and hospital acquired infections.

Over time, the Commonwealth will move to increase the link between health and hospital performance and funding — particularly in critical pressure points such as elective surgery and emergency departments. As part of its national leadership role, the Commonwealth will be alerted to poorly performing hospitals (for example in the event of continuing failure to meet emergency department targets, or poor quality and safety outcomes) and will require states to step in and fix these problems.

Improved clinical governance will be a key feature of the new system. Services that are of low quality, unsafe or based on poor evidence result in poorer care for patients, and increased cost to the system. Governments need to support clinicians to lead the drive towards continuous improvement in quality and safeguarding high standards of care, as they are the experts in this field.

This would include developing and using clinical guidelines that, while set by clinicians and experts nationally, are applied at the local level and contribute to redefining local service mix and approach. Feedback from the consultations suggests that clinicians are seeking this involvement. Reconnecting clinicians as partners in planning and delivering health care is fundamental to health reform.

A combination of enhanced data collection and reporting (for example through activity based funding), more decentralised management of hospitals (through Local Hospital Networks), development of clinical standards (with extensive clinician involvement), and local initiatives will provide rich information for clinicians to be able to reflect on their own practices and drive continuous improvement. As a result, more patients will receive high quality care that is aligned with best practice.

For its part, the Commonwealth will provide leadership in relation to safety and quality by promoting national clinical standards.

National governance functions to drive increased accountability and transparency

National standards will be underpinned by three new national functions for performance reporting and auditing, pricing hospital costs and clinical standards (to evolve from the Australian Commission on Safety and Quality in Health Care):

- › Monitoring and reporting will be undertaken on the performance of the whole health system and that of individual hospitals. This will provide **clear and transparent reporting** on public and private hospital performance, as well as state performance, and independent reporting on the Commonwealth's primary health care performance.
- › An independent umpire at arm's length from governments will set the **nationally efficient price** (including transitional prices), determine the scope of the activity based funding system and provide independent, binding arbitration on cost-shifting. This will reduce the blame game on funding issues.
- › Setting and monitoring national **quality and safety standards**, and working with clinicians to identify best practice clinical care, to ensure the appropriateness of services being delivered in a particular setting.

Clear and nationally consistent performance information will hold hospitals and state governments accountable for meeting performance standards. For the first time, this will include information on individual public and private hospitals. This and other performance information — including on the Commonwealth Government's performance in primary health care — will be publicly released to provide Australians with more information than ever before about the performance of their local hospital, and of their health system at large. This information will also help health providers promote a culture of continuous improvement.

How the Government will implement this reform

The Commonwealth Government will work with state governments, clinicians and local communities to develop local performance standards and information that is useful for patients in evaluating the care they receive.

Over time the Commonwealth will also seek to increase the link between performance and funding to promote a culture of continuous improvement.

CHAPTER 6: LOCAL HOSPITAL NETWORKS TO DRIVE ACCOUNTABILITY AND PERFORMANCE

The Government will introduce Local Hospital Networks to run small groups of hospitals, so that hospitals better respond to the needs of their local community. Local Hospital Networks will collaborate to provide patient care, manage their own budgets, and be held directly accountable for their performance.

A hospital system without enough clinical and local engagement

Health governance structures vary across Australia, from highly centralised models to those that are more devolved to the hospital level. For example, the Victorian system is comparatively devolved, with separate health authorities operating public hospitals. By contrast, New South Wales has a more centralised system with health and hospital services managed by a smaller number of Area Health Services.

In the Government's consultations, many clinicians and local communities made it clear they do not feel they have the opportunity to be involved in decisions about the delivery of health services in their communities. This is a particular issue in rural and regional communities. The result is that services are not responsive to local needs and opportunities to improve clinical safety and quality are lost.

A lack of ownership and ability to drive change at the hospital level can lead to low staff morale. The NHHRC concluded that effective clinical governance is a vital element in retaining our health workforce. Clinicians need to be closely linked to decision making processes to contribute knowledge, advice, leadership and guidance on clinical issues and service planning. This will result in real improvements in care quality and safety.

Local Hospital Networks with the flexibility to improve performance

The Government will require states to introduce Local Hospital Networks — small groups of public hospitals with a geographic or functional connection, large enough to operate efficiently and to provide a reasonable range of hospital services.

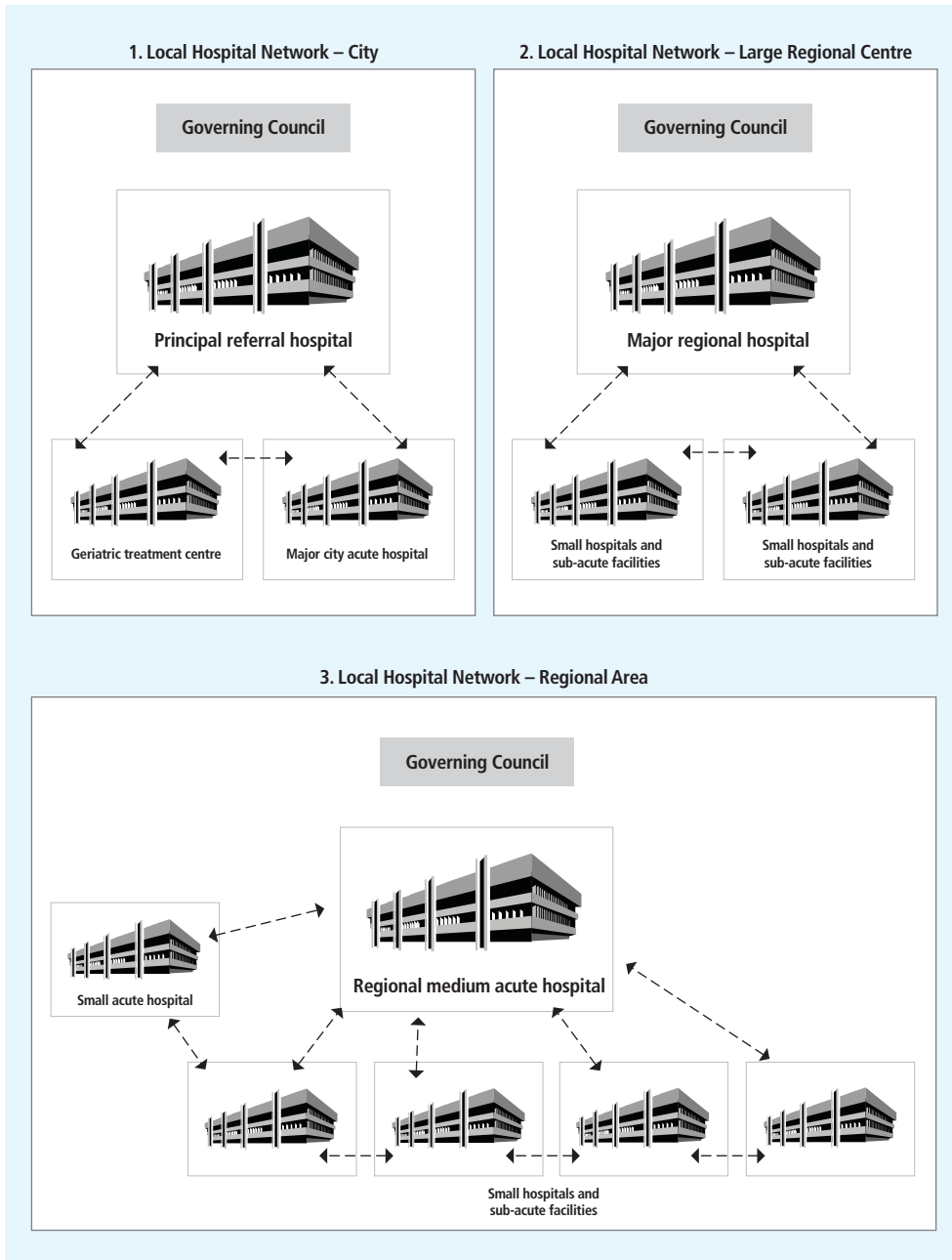
Networks will be responsible for making decisions on the day to day operations of hospitals within their Network. This includes planning at the Network level to deliver on performance standards and manage budgets. Performance at a Network level will be published and transparent to clinicians and the broader community, on a nationally comparable basis.


Networks will be responsible for delivering on agreed services and performance standards. This negotiated outcome could be formalised through an annual “service contract” — in which the state would set out a target for the amount of hospital services to be purchased, and the Network would set out the performance targets and benchmarks that it agreed to reach. In general, service contracts will leave significant flexibility for Networks to determine the most appropriate service mix to meet their performance targets and the needs of their community.

Devolving decision making to Local Hospital Networks will give communities and clinicians a greater say in how their hospitals are run, and avoid the sometimes rigid management by remote health bureaucracies.

Networks will be established as separate state statutory authorities. They will comprise between one and four hospitals in most networks, with regional networks potentially including more small hospitals. In consultation with local communities, states will have the flexibility to determine the regional, rural and remote network structure that best meets the needs of these communities and best takes into account the challenges of managing multiple small hospitals. This will include deciding whether to incorporate smaller regional and remote hospitals within larger Local Hospital Networks, or whether to create further Networks. Networks will avoid the fragmentation and duplication that would come from individual hospitals operating independently from each other, and also avoid the centralised controls and excess layers of bureaucracy that characterise some systems.

Figure 10: Illustrative models of Local Hospital Networks





The Commonwealth Government expects that Local Hospital Networks should be established by states within current health department staffing levels. States will be expected to restructure their health departments and regional structures so that people, along with management responsibilities, are devolved to Networks. As a result, the Commonwealth Government will not provide funding for this specific initiative.

Professional governance councils to drive local responsiveness and improve efficiency

Local Hospital Networks will have a professional Governing Council and Chief Executive Officer (CEO), who will be responsible for delivering agreed services and performance standards within an agreed budget. Governing Councils will include local health, management and finance professionals, with an appropriate mix of skills, expertise and backgrounds. Members will need to have the professional capability to run the large, complex organisations that most Local Hospital Networks will be. Council members will be appointed under state legislation. Each Network's CEO will be appointed by the Council and accountable to the Council.

The devolution of management accountability, combined with paying hospitals directly, places incentives on local managers and clinicians to increase service levels and reduce costs. This will mean that a local hospital should no longer have to seek the approval of a large bureaucracy for matters that relate to the day-to-day delivery of hospital services. Where a Local Hospital Network operates more efficiently, they will be able to locally retain and re-invest the financial benefits. In addition, future Commonwealth Government payments will be designed to reward Networks for good performance — and provide Networks with local flexibility and choice in how to invest the proceeds of good performance.



The role of state health departments

State health departments will have a different role in this system. State health departments will specialise in system-wide service planning and performance management issues, and work with Networks to negotiate service contracts, meet unanticipated challenges, transfer good practice and identify and remediate poor practice. Some functions, such as procurement, may be more effectively administered at a state level. Networks will be the employers of hospital staff, but with conditions of employment managed by states.

In circumstances in which independent and transparent reporting concludes that Network performance is good, Governing Councils and CEOs could expect relatively 'light touch' management from states in an earned autonomy system. Conversely, where Network performance is not meeting the performance standards outlined in the service contract, state health departments will take a more visible and intrusive role. As a last resort, the Council may decide to remove the CEO, or the state Minister may choose to remove the Chair of the Council, or both. As part of its national leadership role, the Commonwealth will be alerted to poorly performing hospitals, and will require states to step in and fix these problems.

Further detail on the distribution of roles and responsibilities across the unified Australian public hospital system is provided in figure 11 below.

Figure 11: Proposed roles and responsibilities in the National Health and Hospitals Network

Decisions relating to public hospitals	Local Hospital Networks	Regions (e.g. Area Health Services)	States	National
Determine efficient price, pay 60% for each service provided, and pay 60% of other costs including capital				◆
Pay remaining costs, including any costs above the efficient price			◆	
Capital planning and management			◆	
Capital ownership			◆	
Performance metrics and target setting				◆
Standards setting, guidelines, quality and safety and national clinical leadership				◆
Receive Commonwealth funding for services	◆			
Hospital workforce planning			◆	◆
Performance management and remediation			◆	
Agree local activity targets, service mix and provision for highly specialised services	◆		◆	
Provisioning services between facilities	◆			
Industrial relations negotiations			◆	
Procurement	◆		◆	
Corporate services (human resources, payroll, etc.)	◆			
Managing operational budget	◆			
Local implementation of clinical guidelines and pathways	◆			

◆ Proposed location



Clinical leadership to drive continuous improvement

Clinical leadership will be an integral part of the design of Local Hospital Networks. There will be clinical representation on the Governing Council, and Networks will work with local clinicians to incorporate their ideas and perspectives into the day to day operation of the hospitals.

Driving integration beyond public hospital doors

Networks will need to develop a number of critical relationships with other parts of the health and hospital system. Good communication between public and private hospitals will continue to be necessary, as will care pathways and linkages with local primary health care and aged care providers. Many Networks will have strong engagement with university clinical schools and research centres, and this engagement will be critical to translating clinical research into clinical practice, ongoing professional development and training the next generation of clinical leaders.

With the introduction of Networks, the Australian public will see hospitals become more accountable and responsive to local communities. Patients will receive better care through stronger clinician engagement in hospital decision-making. Hospitals will be accountable for treatment outcomes, responsive to their patients' needs, and make active decisions about the control of their own budget.

How the Government will implement these reforms

In establishing Local Hospital Networks, states will be asked to create groupings of hospitals that can ensure geographic linkages, management quality, economies of scale, an appropriate service mix, and referral pathways within the Network:

- › In cities, the Networks will be built around each principal referral hospital or specialist hospital.
- › Smaller city hospitals will be incorporated within these Local Hospital Networks on the basis of logical links to lead hospitals, whether through patient catchment or referral linkages.
- › In regional Australia, the Networks will be built around each large regional acute hospital.
- › States can decide whether to incorporate smaller regional and remote hospitals within these Local Hospital Networks, or whether to create further Networks.

CHAPTER 7: PAYING LOCAL HOSPITAL NETWORKS DIRECTLY FOR THE SERVICES THEY PROVIDE

The Commonwealth Government will pay 60 per cent of the efficient price of every public hospital service provided to public patients.

The Commonwealth Government will directly pay Local Hospital Networks for each service they provide, according to a national efficient price determined by an independent umpire.

This transparent system of activity based funding will provide Local Hospital Networks with national consistency in their funding, and give them flexibility to shape the mix of services they deliver.

Too much inefficiency and waste

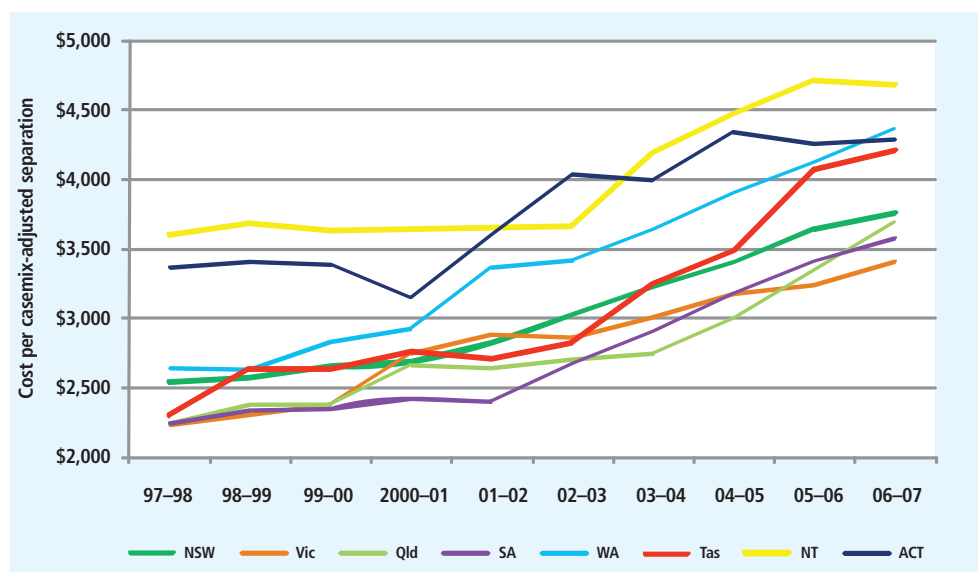
Today, the Commonwealth supports the delivery of free public hospital services through block grant funding paid to the states. Each state then determines funding for individual hospitals. There is considerable variation in mechanisms for payment to individual hospitals around the country, though many states are shifting to some form of activity based funding for acute care.

The differing payment mechanisms for public hospitals often reflect the structures that have developed in particular states over a period of time and the considerable variation in costs across different hospitals. For example, small hospitals — such as rural hospitals — with variable throughput and capacity, and children’s hospitals and referral hospitals, tend to have higher costs for particular procedures than general hospitals. In addition, funding to hospitals often does not reflect service levels or local needs.

At a time when hospitals are struggling to meet current levels of demand, hospitals need to improve their efficiency — to keep downward pressure on costs, and to free up resources to meet increasing demand. The Productivity Commission estimates that some public hospitals may be running up to 20 per cent less efficiently than best practice.

Available data suggests that the efficiency of public hospitals varies substantially between states, indicating there is significant room for improvement even after taking into account geographic and population variation between states.

Figure 12: Recurrent cost for each hospital admission




Source: National Hospital Cost Data Collection, 2009.

Reforming how we pay for hospitals

The Commonwealth Government will increase the efficiency and transparency of public hospital funding by directly funding Local Hospital Networks for each service provided to a patient, through activity based funding. Local Hospital Networks will work with states to determine the range and number of services each Network will provide. Local Hospital Networks will have the assurance of directly receiving payments linked to the number and type of services that they provide. These changes represent a significant departure from current arrangements, under which the Commonwealth contributes to public hospital funding through block grants, which are not explicitly tied to the efficient delivery of services.

Under the new arrangements, the Commonwealth will fund 60 per cent of the efficient price of every public hospital service Local Hospital Networks provide. Currently there are constraints on growth caused by workforce, infrastructure and limits on funding. While some controls on demand for hospital services are necessary, the current constraints create waiting lists for elective surgery and waiting times for emergency departments that are out of step with clinical standards and community expectations.



By providing 60 per cent of the efficient cost of public hospital services and also holding full funding and policy responsibility for primary health care, the Commonwealth will also have a financial incentive to ensure that Australians do not unnecessarily visit hospitals when they can be cared for more appropriately in the community.

International experience suggests that activity based funding in concert with effective clinical leadership and a strong safety and quality regime can support improvements in quality and patient care. This has the capacity to slow the rate of growth in hospital costs over time, thereby increasing the long-term sustainability of health care funding.

These reforms will help to ensure that hospital financing can dynamically adjust to:

- › shifting populations;
- › local demographic characteristics;
- › changing costs of delivering medical services from technological and clinical innovation; and
- › the complexity and location of delivering hospital services.

The Commonwealth will move to a nationally consistent patient level costing and pricing regime for public hospitals over time. This will be undertaken through the establishment of an activity based funding unit price, a series of loadings that adjust the price for the most important patient and hospital factors, and a series of cost weights that reflect the cost differences between different diagnoses and procedures. To do this, the Government will accelerate the activity based funding work program agreed with states at COAG in November 2008.

Once fully implemented, the majority share of the funding for every public hospital in Australia will be linked to the number and type of actual services they deliver. The implementation timeline is set out below.

An independent umpire to determine the efficient price

To ensure that the nationally efficient price is determined on a fair and equitable basis, an independent umpire will set the nationally efficient price and advise the Government on appropriate timelines and path for transition for all hospital services.

In setting the nationally efficient price, the umpire will be required to strike an appropriate balance between reasonable access, clinical safety, efficiency and fiscal considerations. Price loadings will be established to recognise, for example, the particular circumstances and health care needs of people living in rural Australia and Indigenous Australians.

The umpire will determine the scope of the activity based funding system and will also provide independent arbitration on cost-shifting and boundary issues, both between the Commonwealth and the states, and cross-border charging between states. The objective of the umpire would be to resolve cost-shifting issues in a definitive, lasting and nationally consistent manner. It will engage with clinicians on technical issues to ensure that the efficient price continues to reflect the actual cost of providing hospital services, and developments in best practice.

The umpire will also advise on the mechanism to provide the Commonwealth's contribution to teaching and research (as outlined in chapter two).

Driving efficiency — within Local Hospital Networks and across the system

Payments on the basis of an efficient price will help drive efficiency in all hospitals across the country.


Box 6: Operational efficiency

Operational efficiency means eliminating the unnecessary use of resources in the production and delivery of services. In hospital systems, operational efficiency can be achieved by reducing length of stay, increasing quality, and looking closely at the reasons for significant variations in clinical practice.

The use of activity based funding will drive increased operational efficiency across the hospitals system as it explicitly links funds allocated to services provided. It also allows for easy identification of underperforming providers so that the cause of underperformance can be remedied, while lessons from high performance can be disseminated.

The increased operational efficiency from activity based funding will provide savings for taxpayers or help fund additional services.

Although the precise efficiencies from activity based funding are difficult to estimate, the NHHRC estimates that the introduction of activity based funding will lead to savings of between \$0.5 billion and \$1.3 billion each year.



Those Local Hospital Networks that deliver high quality services more efficiently will be able to reinvest in further innovation or more services, and have the flexibility to shape local services according to local needs. The need for payments to be passed through state and regional health bureaucracies will be avoided. This reform will give the Commonwealth and the community confidence that in the future, additional investment of scarce new health funds is being used as efficiently and effectively as possible.

States will be required to be transparent about their funding contribution for each public hospital service, using the same nationally consistent activity based funding approach.

The combination of funding for services actually provided and new national transparency measures will mean communities will have more information than ever before on how well hospitals are performing, how their hospitals are funded, and what services are provided to them.

This combination will also allow ready identification of high-performing hospitals, as it will allow a straightforward comparison of the costs across different hospitals in providing the same hospital service. Once high-performing hospitals are identified, they will be able to share their effective and innovative practices with other hospitals, helping to create a self-improving hospital system. Moreover, states will be able to easily identify hospitals that are struggling and make early interventions to lift hospital performance.

How the Government will implement this reform

To minimise disruption in hospital services and ensure that states are not worse off, activity based funding will be phased in over time, so that:

- › From 1 July 2011, the Commonwealth will increase its funding contribution to 60 per cent of recurrent expenditure on public hospital services, research and training, and planned new capital expenditure. These payments will be made to the states.
- › From 1 July 2012, the Commonwealth will progressively shift this funding to activity based funding paid directly to Local Hospital Networks, starting with admitted patient services and progressing to emergency department and outpatient services.

CHAPTER 8: TAKING A REFORM PLAN TO THE STATES

The Commonwealth Government will take this Reform Plan to the states for agreement at a COAG meeting in April.

Should the states not agree to the Plan, the Commonwealth reserves its right to seek a mandate from the Australian people to implement the Plan.

A comprehensive reform plan

This document outlines a series of major reforms to the structure of our health system that will drive efficiency and better equip the system to meet future challenges.


Over the coming weeks and months the Government will announce additional reforms across a range of areas — including in public hospitals, GP care, health workforce, and e-health. These reforms will tackle key pressure points in the system and deliver better health outcomes for the Australian community.

Putting our proposals to the states

The reforms outlined in this document represent the proposition the Government will take to the states at COAG in April.

Since November 2007, the Commonwealth Government has worked closely with states to deliver much-needed improvements to the Australian health system. These include increasing public hospital funding, tackling pressure on emergency departments and elective surgery waiting lists, and training more doctors and nurses.

However, greater effort is required to ensure the long-term sustainability and quality of Australia's health system. The Commonwealth Government calls on state governments to continue the cooperation they have shown over the last two years to implement the important reforms contained in this Plan. These reforms are necessary to provide Australian taxpayers with a high quality, sustainable health care system into the future.



Under the National Health Reform Plan, in return for providing a secure funding base for public hospitals into the future, the Commonwealth will require the states to commit to system-wide reform to improve public hospital governance, performance and accountability. These include the establishment of Local Hospital Networks, and cooperation with the Commonwealth on transferring funding responsibility for state-funded general practice and primary health care services.

The Commonwealth Government will continue working closely with state governments through the COAG process to ensure the reforms in this plan are implemented as quickly as possible. These essential reforms are required as building blocks for future reforms, and to ensure that additional investment in the system is used efficiently and effectively.

Should the states not agree to the Plan, the Commonwealth also reserves its right to seek a mandate from the Australian people to implement the Plan. Furthermore, consistent with the Government's previous commitments, the Commonwealth also reserves the right to then proceed to a full funding takeover of the system in the future.

The reforms outlined in this document are ambitious. Their implementation will require commitment to reform from all levels of government, as well as from the doctors, nurses and other health professionals who make up our health system.

As the NHHRC made clear, the Australian health system is at a tipping point. After extensive consultation with the Australian community, the Government is more convinced than ever that the time to act is now. Bold reform is necessary to ensure that Australians can access a high quality health system that is sustainable into the future.

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