

## 12. Strengthening the governance of health and health care

### Key messages

- There is widespread dissatisfaction with the fragmentation of services on the ground and that the system doesn't work together as a whole. This is often seen as being due to problems of governance and the 'blame game'.
- The public does not find it easy to know which government to hold to account for their access to health care and the quality of that care.
- There is a mismatch between which government raises the revenue and which government spends it. This creates complexity in the management of the health system, and makes national leadership more difficult.
- No one government has an understanding of, or exposure to, the health system as a whole.
- There are insufficient opportunities for people and their families to participate and have their views heard in the health system.
- Separate funding streams distort priorities and cause problems in service delivery, especially in primary health care.

## Our reform directions and options

12.1 We propose a range of functions that should be led and governed at the national level, including leadership for patient safety and quality (including service accreditation), health promotion and prevention, professional registration, workforce planning and education, performance reporting, private hospital regulation, and technology assessment.

12.2 We propose that the Commonwealth should take responsibility for policy and funding of all primary health care.

12.3 We propose to give further consideration to the following three options for reform of governance:

- (A)** *Shared responsibility with clearer accountability.* Retain both Commonwealth and state and territory involvement but re-align responsibilities between them, with the Commonwealth:
- becoming responsible for all primary health care funding and policy;
  - paying to states and territories a significant proportion per episode of the efficient costs of inpatient treatment and of emergency department treatment (set at, say, 40 per cent); and
  - paying, using a casemix classification, 100 per cent of the efficient costs of delivery of hospital outpatient treatments.

This would be established through a National Health Strategy covering all health policies and programs, underpinned in turn by eight bilateral agreements between the Commonwealth and each state and territory.

- (B)** *Commonwealth to be solely responsible for all aspects of health care, delivering through regional health authorities.* Transfer all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing and funding:
- regional health authorities to take responsibility for former state health services such as public hospitals and community health services, in parallel to continued national programs of medical and pharmaceutical benefits and aged care subsidies.

- (C)** *Commonwealth to be solely responsible for all aspects of health and health care, establishing compulsory social insurance to fund local delivery.* Transfer all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing:
- a tax-funded community insurance scheme under which there would be multiple, competing health plans for people to choose from, which would be required to cover a mandatory set of services including hospital, medical, pharmaceutical, allied health and aged care.

## 12.1 The \$94 billion dollar question

Governance – or who should ‘run’ the health system – is without a doubt the single most controversial issue we have been asked to tackle

■ Governance – or who should ‘run’ the health system – is without a doubt the single most controversial issue we have been asked to tackle.

It is an issue on which people hold very strong, and sometimes, opposing, views. In many of the discussions we had around the country, the issue of governance was the not very well-hidden ‘elephant in the room’. It could equally be labelled the ‘\$94 billion dollar question’: Who should be responsible, and how, for the \$94 billion we spend annually on health services across Australia?

We begin this chapter by presenting some of the diversity of views we heard and read on how to improve the governance of the Australian health system.

## 12.1.1 What do individual consumers and health professionals think?

First, we present some of the views we heard from consumers and frontline health professionals during our ‘listening tour’ across all states and territories (see Figure 12.1). Many consumers – or users of the health system – simply wanted someone to ‘fix the system’, whether that related to public hospital waiting lists or lack of access to health services in rural areas. People working in the health system talked about problems with the level of bureaucracy and cost-shifting between governments. While some people were nervous about giving greater power to the Commonwealth Government, many people blamed problems with public hospitals on state governments.

Without being specific on the detail, a strong message we heard from many consumers and health professionals was a desire for ‘national leadership’ coupled with ‘local decision-making’ or ‘local flexibility’. The ‘one health system’ idea meant different things to different people. For some people, it was akin to the ‘railway gauge’ concept: everyone should have access to the same new cancer drugs or affordable patient transport, and the health system should be the ‘same’, no matter whether you lived in Canberra or Coober Pedy. For other people, ‘one health system’ meant simplifying and streamlining the many different health ‘programs’ so that people could get the services they needed, without having to navigate the maze of Commonwealth and state-funded health services. For yet other people, one health system meant being assured that someone – most often viewed as the Commonwealth Government – would take responsibility for adequately funding the health system. We return later to the concepts of ‘national leadership’ and ‘local flexibility’.

■ A strong message we heard from many consumers and health professionals was a desire for ‘national leadership’ coupled with ‘local decision-making’ or ‘local flexibility’

Figure 12.1: The community has many views on how the health system should be governed

*In our consultation meetings across the country, one of the most commonly discussed issues was how the health system should be governed.*

*Some people were all for abolishing the role of the states and territories:*

*National health system – we need firstly to reduce the bureaucracy. The best way to do that is to abolish the state health ministries and departments and to have a national health system. (Health professional, Dubbo, 3 June 2008)*

*Others were sceptical about options involving more decisions being made in the national capital:*

*I’m a nurse, we’re sick of being told over here by Canberra what to do and what’s best for us ... without any consultation. We are sick to death of hearing things from Canberra. Local issues are not considered when funding is offered. You have people sitting in Canberra saying ‘yes you can have this grant’ or ‘no, you can’t’ never having seen Geraldton and the resources or the distances here. (Nurse, Geraldton, 8 July 2008)*

*Some proposed less sweeping changes, looking for adjustments to existing arrangements that would make responsibility and accountability clearer:*

*I think that I’d just like to really see that there’s a clear responsibility for health delivery between the Commonwealth and the states. For example, that the Commonwealth take on primary care and make it work for all people across Australia, rural remote Australia and that the states do have full responsibility for hospitals, emergency, rehabilitation. And that there are some solutions for the connection between those two systems made that are fairly clear so that basically everybody knows how, from the people in the street through to the top bureaucrats, what the system is and who’s got responsibility for it. (Physiotherapist, Cairns, 17 June 2008)*

*The most consistent view was the desire for a single national health system:*

*... could we please have a national system? I’m really very, very well aware of the amount of duplication that happens with Commonwealth and state. There’s all this reporting and evaluation, cost shifting and it’s a nightmare and it drains money from the system. (Health professional, Hobart, 28 May 2008)*

*I think if we did away with one level of administration we would save so much money and seeing as budget seems to be the top priority in running hospitals. I think there is too much administration and not enough health care, acute health care. (Consumer, Dubbo, 2 June 2008)*

## 12.1.2 Other views on governance

While many consumers and health professionals wanted 'change', they did not necessarily have well-developed views about how to get from 'here' to 'there'. Working out how to 'fix' the governance of the Australian health system is, after all, neither most people's day job, nor their main recreational hobby.

We commissioned some experts to prepare a discussion paper that examined different options for reform of Commonwealth and state governance responsibilities for the Australian health system.<sup>1</sup> We also received many submissions from health sector peak organisations, professional colleges, state governments and academic experts that offered ideas on both the diagnosis and the prognosis for health system governance. We turn now to some of these views.

Some major stakeholders are advocating quite fundamental reforms to how our health system is governed

- First, it is obvious that some major stakeholders are advocating quite fundamental reforms to how our health system is governed.

The Australian Health Care Reform Alliance proposed that a major element in health system reform should involve the concept of 'funds pooling', arguing that:

*It is widely believed that pooled funding would help address accountability and equity for patients and providers, and provide greater equity of access. It also has the capacity to result in greater equity between regions and population groups. The reduction in the number of health funding sources through pooling also has the capacity to lower administrative costs and thus reduce per capita health care expenditure or free up some of the existing expenditure for new purposes.<sup>2</sup>*

The alliance identified six different models by which funds could be pooled. Two of these options involved assumption of full financial responsibility for the health system by either the Commonwealth Government or the state and territory governments. The other four options involved different combinations of pooling or combining funding at the regional level or for specific population groups or on a voluntary basis. However, the Australian Health Care Reform Alliance does not have a preferred model, instead suggesting that further examination of the range of models is warranted.

Other groups see 'funds pooling' as a transitional step towards the ultimate goal of the Commonwealth assuming full financial responsibility for the whole health system. For example, the Chamber of Commerce and Industry of Western Australia argues that:

*Full funding responsibility should be transferred to the Australian Government as the single public funder of health services. As a transitional arrangement, Chamber of Commerce and Industry supports the establishment of a joint Commonwealth/Western Australian Health Commission through which Commonwealth and State health funding could be pooled.<sup>3</sup>*

But some groups see the concepts of 'funds pooling' and 'Commonwealth responsibility' as mutually exclusive. The Royal Australasian College of Surgeons argues for clear accountability and no 'cross-over' or pooling of Commonwealth and state funds for health services as follows:

*The College has long been a supporter that all the health system should be fully federally funded with the responsibility and accountability residing with the federal minister. The College and a number of its associated specialist societies still strongly believe that only by having one funder will accountability and responsibility be substantially improved.*

1 J Dwyer and K Eager (2008), Options for reform of Commonwealth and state governance responsibilities for the Australian health system, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

2 Australian Health Care Reform Alliance (2008), Submission 446 to the National Health and Hospitals Reform Commission.

3 Chamber of Commerce and Industry of Western Australia (2008), Submission 62 to the National Health and Hospitals Reform Commission.

*However, the College recognises the constitutional and political challenges of this. Whatever the model achieved, there needs to be minimal cross-over between funding streams to achieve optimal care.<sup>4</sup>*

While many stakeholders support a stronger role for the Commonwealth Government, there are quite different views about which health services or funding streams should be picked up by the Commonwealth. The starting point for most groups (which was also reflected in the views of ordinary Australians who attended our community and health professional consultations) was for the Commonwealth to take responsibility for public hospitals. But some stakeholders wanted an even more expanded role for the Commonwealth. For example, Gavin Mooney argued that:

*There is so little sense in taking over the hospitals nationally and even less in taking over only the poorly performing ones without taking over the whole health service. There is a very good case for the Commonwealth financing and running the whole health service.<sup>5</sup>*

Others go even further. Ian McAuley and John Menadue argue for a 'single national insurer' covering not only all publicly-funded health services (including public hospitals, medical services, community health services) but also all privately-funded health services (such as private hospitals).<sup>6</sup>

These views remind us that when most people talk about the Commonwealth becoming the 'single funder', they are actually using the term to mean 'single public funder' with a continued role for a complementary private health insurance sector. We have adopted this distinction in this chapter, and our discussion of governance options is about the roles of Commonwealth, state and territory governments for publicly-funded health services.

Some stakeholders see potential for benefits from greater 'blurring' of the distinction between 'public' and 'private' health services, linked to major governance reforms. Catholic Health Australia believes that the Commonwealth should take on responsibility for the whole health system, but that:

*Having responsibility for financing the health care system does not mean the Commonwealth would run services – in our view services are best delivered by the organisations that can provide the most efficient, highest quality and cost-effective services whether they are government or non-government organisations. The significant role played by the private sector in both the provision and financing of health services in providing additional choices and innovation needs to be acknowledged.<sup>7</sup>*

Catholic Health Australia goes further in offering to participate in trialling direct funding by the Commonwealth Government of funding public hospitals.

While there is thus a strong groundswell of interest (and some partially developed proposals) for major governance reforms, some stakeholders hold equally strong views about the risks associated with changing how we govern the Australian health system.

Chief among these is the Australian Medical Association (AMA) who urged us to apply the 'first, do no harm' principle in our deliberations on health reform. The AMA cautioned about the 'considerable risk' associated with 'big bang' reform.

*The AMA does not believe that 'big bang' reform in Commonwealth/State health financing is feasible. There is too much inertia and too strong a vested interest on the part of governments in the system as it is. A major change in responsibilities would have a high chance of raising complex and hotly contested issues such as a redistribution of tax powers. We expect that these issues will remain insoluble. There is plenty of untapped potential for incremental reforms that could lift system performance and improve patient outcomes.*

■ There are quite different views about which health services or funding streams should be picked up by the Commonwealth

4 Royal Australasian College of Surgeons (2008), Submission 406 to the National Health and Hospitals Reform Commission.

5 G Mooney (2008), Submission 275 to the National Health and Hospitals Reform Commission.

6 I McAuley and J Menadue (2007), A health policy for Australia: Reclaiming universal health care, Centre for Policy Development, at: <http://cpd.org.au/category/all-articles/health/reclaiming-universal-care>

7 Catholic Health Australia (2008), Submission 57 to the National Health and Hospitals Reform Commission.

*However, as we have noted ..., efficiency gains cannot solve the under-resourcing of the sector. More funding is needed and the Commonwealth government needs to pick up the ball it previously dropped.*<sup>8</sup>

The AMA further noted its concerns that one of the risks of ‘big bang’ governance reforms is that ‘political consensus will be possible only around very limited and poor quality reforms’.

Similar views were echoed in some of our other submissions. Other elements of these concerns related to: the potential for governance reform to become the ‘only game in town’; that reform needed to focus strongly on better organisation and delivery of health services for people on the ground; and that governance reform did not equate to a single ‘magic bullet’ solution for all the problems with the health system.

For example, the South Australian Health Department argued that:

*Whilst a clear separation has inherent value it does not seem to take account of the complexity of health care and the myriad of providers in place. Separating roles too much may not resolve the challenges of providing integrated service. Regardless of how respective roles are divided up, there remains an integration issue between those different roles. There may be nothing wrong with having shared roles and responsibilities; the important factor that needs to be focused on is how to provide seamless, person centred care across the service continuum.*<sup>9</sup>

Professor Stephen Leeder cautions against building solutions that start from the problems of blame and cost shifting. He further suggests that:

*At a time when most developed nations are looking at ways to decentralize and ‘federalize’ health services we should be wary about easy centralizing fixes.*<sup>10</sup>

And Paul Gross argues that reforms in other areas should take priority over governance reforms:

*The Commission should not waste its time debating ‘big bang’ reforms that require a revolution. Long before 2020, we can fix the current messiness by new financial incentives, use of modern information technology, and alternatives to the Council of Australian Governments as a major change agent.*<sup>11</sup>

There is not yet consensus on a ‘single solution’ to how to improve governance of Australia’s health system to ensure better health outcomes for people

■ In summary, our digest of the many views we heard through consultations and submissions was, not unsurprisingly, that there is not yet consensus on a ‘single solution’ to how to improve governance of Australia’s health system to ensure better health outcomes for people.

Where to from here?

Given the complexity of these issues, and the diversity of views on both the problems and the solutions, we have decided that the most valuable contribution we can make in this, our Interim Report, is to clearly present the issues and choices on governance reform. This will allow a more well-informed community debate about the \$94 billion dollar question of who should ‘run’ our health system.

Accordingly, in the remainder of this chapter, we:

- describe the critical features of existing governance arrangements and outline some of the factors that will need to be considered in any major reform of health system governance (Section 12.2);
- identify some important functions and roles that we believe would benefit from national leadership (irrespective of how the health system is governed) (Section 12.3);

8 Australian Medical Association (2008), Submission 445 to the National Health and Hospitals Reform Commission.

9 South Australia Health (2008), Submission 458 to the National Health and Hospitals Reform Commission.

10 Menzies Centre for Health Policy (2008), Submission 420 to the National Health and Hospitals Reform Commission.

11 P Gross (2008), Submission 448 to the National Health and Hospitals Reform Commission.

- identify some approaches to enhancing local flexibility and strengthening public voice (irrespective of how the health system is governed) (Section 12.4); and
- describe three major options that we believe represent genuine opportunities to improve how our health system works for people (Section 12.5).

## 12.2 Critical features of the governance of the Australian health system

### 12.2.1 Government roles in the Australian context

In Australia, responsibility for health care is divided between two levels of government, which each have quite different approaches to funding, and quite different relationships to providers. (We note that while local government has an important role in providing health, community and aged care services, the discussion in this chapter focuses on the roles of the Commonwealth and state and territory governments.)

■ In Australia, responsibility for health care is divided between two levels of government

While the majority of funding of health services in Australia is public, the majority of expenditure on health services goes to non-government organisations and professionals in private practice operating in a regulated, competitive market.<sup>12</sup> The exception is that most state-funded services are provided by government entities – in particular, most public hospitals and many community health services.

In contrast, virtually all health and aged care services supported directly by Commonwealth funding are provided by non-government entities, most of which are private businesses (for example, medical practitioners in private practice, local chemists, pathology and radiology companies, and aged care). The same holds true for Commonwealth indirect support for health care through the private health insurance rebate: Commonwealth funding support mostly flows to support access by consumers to private providers of health services.

Put another way, states and territories are directly involved in providing health services through government authorities, whereas the Commonwealth is predominantly involved in funding health services, many of which are privately provided, albeit usually in a highly (Commonwealth) regulated market.

Some of the largest expenditures by government on health services are direct Commonwealth payments to citizens and permanent residents to offset most of the fee per item cost of privately-provided services. Medical and pharmaceutical benefits together represent a little over 30 per cent of all governments' expenditure on health.<sup>13</sup> These are statutory entitlements to fixed reimbursements. These Commonwealth-funded health services are financed by way of standing 'special appropriations' – that is, the law which defines the program also provides for the continuous provision of funds from consolidated revenue to fund payments required by the program. In quasi-law terms, Commonwealth funding is 'uncapped' or open-ended.

In contrast, most state and territory health services are funded by fixed annual grants paid to health services such as public hospitals. To support this, state and territory parliaments make annual appropriations of fixed amounts to fund their health services.

So, both the way in which governments fund, and the relationship they have with health services, are quite different between the Commonwealth and the states and territories.

12 M Foley (2008), *A mixed public-private system for 2020*, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

13 Australian Institute of Health and Welfare (2008), *Health expenditure Australia 2006–07* (Australian Institute of Health and Welfare: Canberra).

In addition to these differences, one of the critically important consequences of the current separation of responsibilities for health between governments is a separation of expertise and perspective.

To put it bluntly, no level of government has a detailed understanding of all aspects of the health sector

■ To put it bluntly, no level of government has a detailed understanding of all aspects of the health sector.

Each level of government formulates policies in relation to its responsibilities that do not take account of the health system as a whole, or are designed to shift costs onto the other. It seems unlikely that anyone would support an approach to economic policy under which the Federal Treasury did not have a detailed understanding of major aspects of the economy, yet such a situation is the norm in health.

## 12.2.2 The Commonwealth and states and territories have fundamentally different capacities to fund health services

In 1942, the states and territories lost their ability to raise income tax to the Commonwealth, in support of the war effort. Since that time, all states and territories have been dependent on grants from the Commonwealth to meet their expenditure commitments, to a greater or lesser extent:

*... the states rely on Commonwealth financial assistance to meet about 40 per cent of their average funding requirement<sup>14</sup>*

This is known as the 'vertical fiscal imbalance', or VFI. Vertical fiscal imbalance is a feature of many federations, but:

*Australia has the greatest degree of vertical fiscal imbalance of any federal country<sup>15</sup>*

including the US and Canada.

Vertical fiscal imbalance is a crucial driver of the 'blame game' in health. States and territories have service obligations which they cannot meet from their own resources, and for which they must rely on Commonwealth grants. Any failure to meet public expectations in relation to state and territory provision of health services inevitably leads to claims and counter-claims about the adequacy of Commonwealth funding to do so.

This is not the whole cause of the blame game, but it is central to it.

## 12.2.3 Consequences for governance and funding of health services

These differences in the nature of government involvement in health care between levels of government in the Australian federation must be central to any discussion of proposed changes to the roles of governments in health.

For example, proposals to increase state exposure to significant additional areas of health spending, even if underwritten by Commonwealth grants, are unlikely to prove acceptable to states and territories.

14 Commonwealth Budget Paper No. 3: Australia's Federal Relations 2008-09 – Part 1: Overview of Australia's Federal Relations, at: [http://www.ato.gov.au/budget/2008-09/content/bp3/html/bp3\\_overview-01.htm](http://www.ato.gov.au/budget/2008-09/content/bp3/html/bp3_overview-01.htm)

15 Public Finance and Vertical Fiscal Imbalance, Research Note No. 13 2002-03, Australian Parliamentary Library, at: <http://www.aph.gov.au/library/Pubs/RN/2002-03/03rn13.htm>

States and territories struggle to manage hospital outlays, even with a system of fixed annual budgets for which they can hold hospital boards and/or managers responsible. States are unlikely to be willing to increase the scope of health services for which they are accountable to the public where their capacity to meet those increased obligations is further dependent on Commonwealth grants.

In addition, in relation to any potential transfer of responsibility for Commonwealth benefit programs to states and territories, the states and territories have little experience in the management of such entitlement-based payments to individuals. They would be very unlikely to accept responsibility for open ended outlays on such programs unless they had very wide discretion to revise program arrangements so as to contain those outlays.

This could lead to a situation where, for example, different pharmaceuticals were subsidised to differing extents in different states, as states exercised their discretion and arrived at different decisions. This could also lead, in turn, to people crossing borders to get treatments or levels of subsidy available in one state or territory but not another. It seems unlikely that such an approach would be more efficient to administer, or have the same capacity, for example, to evaluate and regulate pharmaceuticals, as does the current national approach through the Pharmaceutical Benefits Scheme.

These factors suggest that it would be difficult to increase state government responsibilities for health services without fundamentally altering the revenue base they have to meet such additional responsibilities.

#### 12.2.4 Aligning power with responsibility, and responsibility with capacity to pay

We would suggest that a basic tenet of good governance is that power and responsibility should be aligned. That is, as far as possible, a government should be directly responsible and accountable for the effects on services of its funding decisions. And, conversely, the fiscal implications of policies and program management decisions should rest with the government making the decisions.

In a general sense, then, a government that alters its level of funding for particular health services should be clearly and directly accountable for the consequences of that in terms of people's access to those services.

We would further suggest that the division of spending obligations between governments should be commensurate with their capacity to pay. Absent any major realignment of revenue raising capacity, this means that any proposed realignment between governments of health service and spending responsibilities should see greater direct involvement of the Commonwealth.

It is reasonable to suggest that the 'blame game' in Australian federal relations is significantly a product of lack of adherence to these principles. The blame game in relation to public hospitals is arguably a conscious, sustained and, to a degree, successful attempt by states and territories to increase the Commonwealth's accountability in the eyes of the public for the limitations of public hospital services. States regard this as valid as they maintain that key aspects of Commonwealth policies, ranging from the adequacy of Commonwealth grants to states and territories, to the availability of residential aged care and access to primary medical care outside hospital emergency departments, are crucial in limiting public hospital performance.

- Any proposed realignment between governments of health service and spending responsibilities should see greater direct involvement of the Commonwealth

## 12.3 Functions requiring national leadership

We indicated earlier in Section 12.1 that our consultations across Australia had uncovered a strong interest in 'national leadership' as a core element of the 'one health system' model.

We believe that there is considerable merit in identifying functions that would benefit from being undertaken on a national basis. We have used the word 'national' rather than 'Commonwealth' intentionally. By using this language, we are seeking to indicate the importance of some roles and functions occurring on a consistent national basis. This may well involve collaborative partnership arrangements between the Commonwealth and states and territories, as well as other bodies. National leadership does not necessarily translate to direct Commonwealth control.

We need one health system, not a public health system and a private health system, where 'ne'er the twain shall meet'

■ We also want to indicate strongly that national leadership must involve the effective participation of the whole health sector: public and private health services, and public and private funders of health care. National leadership should not, for example, be about national leadership on the quality of public hospital services only, with no regard to private hospital services. We need one health system, not a public health system and a private health system, where 'ne'er the twain shall meet'.

This framing of the issue – what roles and functions would benefit from national leadership – establishes a different mindset than only discussing whether the Commonwealth or states and territories should 'run' health.

To get the ball rolling on this debate, we have identified the following preliminary set of functions or responsibilities that we are proposing would benefit from national leadership. Importantly, we have cast this primarily as a list of functions or responsibilities. It is not a list of proposed new national agencies. Some of these functions could well be performed by changing or adding to the roles of existing agencies. We would welcome feedback on this listing, and on any other responsibilities that might be added to this listing.

### *National leadership on safety and quality of health care*

Building on the existing responsibilities of the Australian Commission for Safety and Quality in Health Care (which currently is time limited and not incorporated), we see the need to consolidate and align a range of functions that support health professionals in working towards a high quality and safe health system. We also see the need to consolidate and align various service accreditation requirements. Chapter 15 outlines our proposals on safety and quality in more detail, but they include the establishment of a permanent, independent national body to provide leadership on safety and quality, including the development of performance indicators and national patient experience surveys and patient-reported outcome measures.

### *Health professional registration based on competencies*

We support the move to national registration of health professions. This was one of the issues that health professionals raised with us as a major frustration during our consultations:

*So I'm a Director of Nursing and if I could summarise one thing you could do is get rid of the requirements for multiple registrations, multiple checks and multiple accreditations. In my present role I have four registrations in different states, five accreditation systems applicable and four different police checks. A lot of them are obviously redundant!<sup>16</sup>*

As proposed in Chapter 14, we further believe there is a need to move to a system based upon recognition of competencies, rather than simply registration of health professions.

16 Director of Nursing (17 June 2008), National Health and Hospitals Reform Commission consultation meeting with health professionals in Cairns.

## National Clinical Education and Training Agency

As also discussed in Chapter 14, perhaps the biggest single challenge Australia faces for the future of our health system is ensuring we have enough skilled health professionals. To meet this challenge, we believe a single body needs to be given the authority and responsibility to recommend the numbers of course places to be made available, and to fund the requisite clinical placements with the health sector across all health professions. Chapter 14 identifies the other important functions which we believe would benefit from a national approach under this agency.

## National Health Promotion and Prevention Agency

As set out in Chapter 1, we propose the establishment of an independent national health promotion and prevention agency to bring a greater focus to prevention in our health system. Importantly, this agency would have carriage of the proposed Healthy Australia 2020 Goals. It would also be responsible for building the evidence base, capacity and infrastructure that is required so that prevention becomes the platform of healthy communities and is integrated into all aspects of our health system.

We have further proposed that this agency would collate and disseminate information about the efficacy and cost-effectiveness of health promotion and prevention interventions.

## National health intervention assessment

Australians already benefit from a robust, national approach to decision-making involving the evaluation and funding of pharmaceuticals and medical services. In particular, Australia is regarded as a world leader in terms of its use of cost-effectiveness analysis in reaching decisions about the public funding and listing of pharmaceuticals on the Pharmaceutical Benefits Scheme.

However, we are also aware that these two national processes sit side by side with a patchwork of other processes for evaluation of new technology, medical devices and prostheses. Some states have established their own technology assessment processes which do not necessarily use the same criteria as the existing national approaches. In addition, there may be only limited channels to assess the evidence on other 'interventions' including allied health services, complementary medicine, or health promotion and prevention activities. We are also aware from our submissions and our consultation meetings that there is considerable duplication across states, across private health insurers, and across individual health services in how they assess and make decisions on which health interventions are beneficial. There is also support for national leadership on this issue. For example:

*ACT Health recommends that the National Health and Hospitals Reform Commission acknowledge that health technology is a major driver of costs and investigate mechanisms to provide a sustainable funding process. ACT Health would support the development of a sensible model to assess which technologies to adopt, similar to the processes used for assessing new pharmaceuticals.<sup>17</sup>*

*We have an enviable system of establishing the value of modern medicines in the PBS price negotiations, some medical technologies are reviewed through the Medical Services Advisory Committee (MSAC), and many more are assessed by joint committees of insurers and manufacturers in a tortuous process that sometimes overlaps with MSAC reviews. Most medical interventions are not subject to stringent evaluation. Most Australians do not know the costs, risks and benefits of the care they consume, and they are facing inexplicable co-payments with modern drugs and medical devices. These gaps in transparency might be filled in part by a national process of technology assessment similar to the process followed by the UK National Institute for Clinical Excellence (NICE), recognising that modern drugs and medical devices are very different in their evidence requirements.<sup>18</sup>*

- Australians already benefit from a robust, national approach to decision-making involving the evaluation and funding of pharmaceuticals and medical services

17 ACT Health (2008), Submission 5 to the National Health and Hospitals Reform Commission.

18 P Gross (2008), Submission 448 to the National Health and Hospitals Reform Commission.

What we are foreshadowing here is our support for the concept of an 'umbrella' approach to the consistent national evaluation of a broad range of health interventions

■ This is a huge and complex issue, and we cannot fully do justice to this issue within our Interim Report. What we are foreshadowing here is our support for the concept of an 'umbrella' approach to the consistent national evaluation of a broad range of health interventions. This does not necessarily imply that the identical approach (or how evidence is used and collected) to decision-making on pharmaceuticals has to be rigidly applied to other health interventions. What it does mean is that we need to move towards more common processes. So, for example, a common approach might be applied to evaluating a range of interventions for their effectiveness in managing obesity (such as a new anti-obesity drug and a new gastric banding procedure), rather than evaluating them separately. It might also facilitate evaluation of new interventions that involve close linkage of diagnosis and treatment (such as personalised medicines, responding to the new genomics – especially in the diagnosis and treatment of cancer – and genetic testing and treatment).

Using the distinction made by Harris and Mortimer in one of our commissioned discussion papers<sup>19</sup>, it may be that a consistent national approach could also be used to evaluate 'clinical prevention' activities (involving interactions between health professionals and individual patients) and medical and pharmaceutical interventions. Continuing our example above, this might mean that we evaluate the value of exercise programs designed by an exercise physiologist in managing obesity in parallel with medical and pharmaceutical interventions. (Our preliminary position is that broader health promotion and prevention initiatives – such as social marketing campaigns – would probably benefit from a separate approach, under the guidance of the proposed national health promotion and prevention agency.)

### *National regulation of private hospitals*

We also heard about the need to reform private hospital regulation.

*The starting point for reform is to rationalise the existing plethora of regulation and reporting requirements imposed on private hospitals. The National Health and Hospitals Reform Commission should establish what information and data is important for private hospitals to report, and require that this information and data be reported once, nationally.<sup>20</sup>*

The Commonwealth Government has a key role in relation to privately-funded hospital services through its responsibility for policy, funding and regulation of private health insurance, as well as its responsibility for medical and pharmaceutical benefits for private patients in hospitals. Over the last couple of decades, private hospitals have been consolidated and are now increasingly owned by chains operating in multiple states. Different regulatory regimes for private hospitals in different states contribute to an oversight burden. National regulation of private hospitals would ensure national consistency and simplify compliance for national private hospital operators and those with hospitals in more than one state.

### *National support for innovation*

Currently, health service innovations are often poorly known beyond the health service in which they were developed, let alone able to be recognised and adopted in other health services across the country. In an environment of tightly constrained resources, the pressures to maximise those devoted to treatment can mean that there is scant investment in fostering, rewarding and disseminating service innovations:

*There is a lack of evaluation and cumulative learning in the Australian health care system. A mass of experimentation is conducted at the local level, through, for example, Divisions of General Practice and Area Health Services, but information on successful innovations is spread haphazardly, with no systematic evaluation. National leadership is needed to transform local successes into initiatives that operate across the health system.<sup>21</sup>*

19 A Harris and D Mortimer (2008), A preventative priorities advisory committee and prevention benefits schedule for Australia, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

20 Australian Private Hospitals Association (2008), Submission 10 to National Health and Hospitals Reform Commission.

21 Menzies Centre for Health Policy (2008), Submission 420 to the National Health and Hospitals Reform Commission.

In Chapter 15, we propose several mechanisms to enhance the national uptake of innovation across public and private health services. This includes an expanded role for the National Institute of Clinical Studies in undertaking a 'clearinghouse' function and the adoption of a range of initiatives to foster the sharing of best practice.

### *National performance reporting and accountability framework*

There is a clear need for improved, public availability of nationally consistent information on comparative health service performance. As we heard:

*My first proposal is that a national report of performance reporting should be available at hospital level, rather than only at aggregated state level ... This would place all Australian hospitals in a national context and provide comparisons for them across Australia.*

- *Hospitals like to strive to be the best and the national context offers a greater challenge. ...*
- *It means we start thinking nationally, as a national health care system with consistent performance and striving for excellence, rather than always at state level.<sup>22</sup>*

Development and implementation of nationally consistent information on comparative health system performance will reduce duplication and overlap, improve consistency, lower compliance costs for organisations that operate services nationally, and enable faster development.

### *National Aboriginal and Torres Strait Islander Health Authority*

As discussed in Chapter 8, improving health and access to health services for Aboriginal and Torres Strait Islander peoples must be given the highest priority. To lead the additional investment we believe is required, we suggest strengthening the purchasing role through the establishment of a National Aboriginal and Torres Strait Islander Health Authority. The Authority would have clear authority and responsibility for purchasing services specifically for Aboriginal and Torres Strait Islander Australians and their families as a mechanism for closing the gap. This Authority would purchase health services from accredited providers with a focus on outcomes and to ensure high quality and timely access.

#### Reform direction 12.1

We propose a range of functions that should be led and governed at the national level, including leadership for patient safety and quality (including service accreditation), health promotion and prevention, professional registration, workforce planning and education, performance reporting, private hospital regulation, and technology assessment.

In conclusion, we want to stress that our proposal for national leadership on some important roles and responsibilities stands independently. We are proposing that this can occur irrespective of other major changes to the governance of health services discussed in Section 12.5.

■ There is a clear need for improved, public availability of nationally consistent information on comparative health service performance

22 M Draper (2008), Submission 265 to the National Health and Hospitals Reform Commission.

## 12.4 Approaches to building local flexibility and public voice

We turn now to the second core issue of local flexibility and local input into decision-making about health services. Again, the approaches we outline below should be considered as integral to driving quality performance across the whole Australian health system. They are not an optional extra. We are proposing that they can, and should, occur irrespective of whether there are other changes to governance arrangements between Commonwealth, state and territory governments.

It was evident that many people wanted 'the best of both worlds'

■ In our consultations, it was evident that many people wanted 'the best of both worlds'. They wanted national leadership shaping 'one health system' – a well-funded system with the same national entitlements and good access and quality outcomes for everyone – but they also wanted 'local flexibility'.

Like the concept of 'one health system', the concept of 'local flexibility' can have many different interpretations. At one extreme, it might mean 'send a blank cheque' and let us decide what health services we need for our community and how best to organise them. But the term was also used by many people to describe their interest in improvements in participatory and consultative structures at regional and local levels. Local flexibility can have many 'shades of grey', depending upon how much the emphasis is on decision-making, consultation, funding or purchasing of health services.

We wanted to take this opportunity to link the concept of 'local flexibility' back to our principle of 'public voice and community engagement' (see Figure 12.2).

Figure 12.2: Our principle on public voice and community engagement

*Public participation is important to ensuring a viable, responsive and effective health and aged care system. This recognises and values the importance of a person's experience of the health and aged care system and in living with their health condition. Participation can and should occur at multiple levels, reflecting the different roles that individuals play at different times in their lives. This includes participation as a 'patient' or family member in using health and aged care services, participation as a citizen and community member in shaping decisions about the organisation of health and aged care services and participation as a taxpayer, voter, and in some cases shareholder, in holding governments and corporations accountable for improving the health and aged care system. Effective participation also recognises the valuable role of advocacy and self-help groups, non-government organisations and other communities of interest that contribute to improving the performance and responsiveness of the health and aged care system. Participation also involves engaging the whole community in priority setting and decision-making about what can be reasonably and equitably provided in the health and aged care system.*

There is clearly overlap between these concepts, although they each add value in their own right. One way of thinking about them is that 'local flexibility' is what is needed for health services to be able to take note of community or collective input into decision-making (and other local processes), while public voice and community engagement has more of an emphasis on the perspectives of individuals and families about their health services and priorities. Moreover, local flexibility is often about flexibility from the perspective of health services. For example, can funding be used to provide services outside those specified in health service 'program' arrangements? What accountability and reporting requirements are health services required to undertake? Are there regional or local structures to encourage joint action on population health and integrated planning across health services? The mirror image of this is how people and their families contribute to shaping their health services.

Recognising that local flexibility and public voice are related, but separate, concepts, we want to highlight briefly some approaches in both these areas that may be relevant to strengthening governance at the local level.

## 12.4.1 Strengthening local flexibility

This interim report canvasses a number of strategies to strengthen local flexibility.

In Chapter 2, we have proposed that service coordination and population health planning priorities could be enhanced at the local level through the establishment of Divisions of Primary Health Care. We see these regional structures as providing one mechanism to 'join up' and strengthen the platform of primary health care services at a local level. We have outlined that these Divisions of Primary Health Care could develop 'wellness and prevention' profiles for their communities. They could also identify current strengths and gaps within service provision. Local flexibility could be enhanced as Divisions of Primary Health Care provide a counter-balance to the views of national and state governments about what is important and how services can best be designed to meet the needs of their local communities.

These approaches are further picked up in our discussion in Chapter 1 where we propose that local communities and health services may want to play a leading role in action towards the achievement of the proposed Healthy Australia 2020 Goals. We have suggested 'local flexibility' as we anticipate that local communities and health services may want to focus on particular goals that resonate with the health priorities identified by their community.

In Chapter 9, we have identified several approaches to encouraging locally designed and flexible models of care in remote and small rural communities. We have proposed that more equitable and flexible funding could be provided through funding remote and small rural communities at the national average of medical benefits and primary health care service funding. This means that, even though such communities may not otherwise access Medicare Benefits Schedule funding, they would be able to have access to equivalent funding dollars. This would allow them to provide primary health care services in a way that meets their needs, recognising the workforce challenges in these communities. We have also proposed the expansion of the concept of the 'multi-purpose service' model to towns with catchment populations of approximately 12,000. Once again, this approach provides the capacity to adapt to local circumstances, providing funds flexibly across health and aged care programs according to community needs.

■ We see these regional structures as providing one mechanism to 'join up' and strengthen the platform of primary health care services at a local level

## 12.4.2 Strengthening public voice

Community participation is a very broad concept and captures a wide range of possible strategies, many of which are important to improving governance at the local and regional level. One useful definition is that:

*Participation occurs when consumers, carers and community members are meaningfully involved in decision making about health policy and planning, care and treatment, and the wellbeing of themselves and the community. It is about having your say, thinking about why you believe in your views, and listening to the views and ideas of others. In working together, decisions may include a range of perspectives.<sup>23</sup>*

The strategies that can be used to give effect to participation range from the passive provision of information, to active consultation with community groups, to involving consumers and the community as partners in decision-making through either formal or informal mechanisms.

One of our submissions provided a useful framework to develop our public voice principle. Sophie Hill and Mary Draper<sup>24</sup> proposed that public voice and consumer participation could be strengthened across four separate dimensions as follows:

23 Victorian Department of Human Services (2006), Doing it with us not for us: Participation in your health service system, 2006–2009, at: [http://www.health.vic.gov.au/consumer/downloads/do\\_it\\_with\\_us.pdf](http://www.health.vic.gov.au/consumer/downloads/do_it_with_us.pdf)

24 S Hill and M Draper (2008), Submission 403 to the National Health and Hospitals Reform Commission.

- Democratic participation – this is based on individual and collective participation in decision making. Strategies include: consultation; involvement in decisions; the use of personal health records; representation; consumer membership on decision-making structures; consumer advisory structures; and accountability to consumers.
- Legal approaches – this is based on defined rights and access to judicial processes. Strategies include: health charters; the right to complain; legal redress; legislation; transparent decision-making; and advocacy.
- Market solutions – this is based on market information to create more responsive services. Strategies include: providing information on health services; marketing; statements of expectations; and consumer surveys.
- Scientific approaches – this is based on the use of statistics and evidence. Strategies include: evidence-based medicine; outcomes data; clinical practice guidelines; patient surveys; and research into the patient experience.

We believe that this provides a useful framework and a broad checklist of strategies to foster a stronger public voice in the health system.

Many of the elements in this public voice framework have been canvassed elsewhere in our report. We have proposed in Chapter 4 that there should be public reporting by public and private hospitals on indicators of access, efficiency and quality of care provided. In Chapter 15, we take this one step further in proposing that all hospitals, residential aged care services and Comprehensive Primary Health Care Centres report annually on their quality improvement and research activities, including reporting on actions arising from investigation of adverse events. We have also proposed in Chapter 15 that an independent national quality and safety organisation should take the lead in the development of a national patient experience questionnaire and patient-reported outcome measures.

In conclusion, we would welcome further feedback on approaches to strengthen local flexibility and public voice in the health system.

## 12.5 Options for better governance

As outlined in Section 12.1, there was a diversity of views from the submissions and consultations about the appropriate roles of Commonwealth, state and territory governments. However, many of the submissions expressed a simple view (for example, that the Commonwealth should take over responsibility), but lacked detail as to how the preferred change might work out on the ground.

The ‘devil is in the detail’ with proposals to reform the governance of the health system

■ The ‘devil is in the detail’ with proposals to reform the governance of the health system. Accordingly, we now outline the detail of three major possible approaches to improving governance of the Australian health system. The three models are:

- Option A – continued shared responsibility between governments, with clearer accountability and greater Commonwealth responsibility for some functions.
- Option B – Commonwealth to have sole responsibility for all aspects of health care, with delivery through regional health authorities.
- Option C – Commonwealth to have sole responsibility for all aspects of health care, with establishment of compulsory social insurance to fund local delivery of health services.

In Chapter 2, we indicated our strong support for the Commonwealth to take greater responsibility for all primary health care services. We want to make it clear that we believe this should occur, no matter what other changes occur to the governance of the health system.

We propose that the Commonwealth should take responsibility for policy and funding of all primary health care.

### 12.5.1 Option A – continued shared responsibility between governments, with clearer accountability and more direct Commonwealth involvement

This option would retain both Commonwealth and state and territory involvement but re-align responsibilities between them, with the Commonwealth:

- becoming responsible for all funding, policy and regulation for primary health care and community health services, including those currently funded by states as already outlined in Chapter 2;
- paying to states and territories a substantial hospital benefit per episode of the efficient costs of inpatient treatment and of emergency department treatment (set at, say, 40 per cent); and
- paying, using a casemix classification, 100 per cent of the efficient costs of delivery of hospital outpatient treatments.

This option would be established through a National Health Strategy covering all health policies and programs, underpinned in turn by eight bilateral agreements between the Commonwealth and each state and territory.

#### *Option A – key features*

Both levels of government would remain involved in funding and decision making about health services, and there would be shared planning of the whole health system, state by state.

An overarching National Health Strategy would be developed and agreed by the Commonwealth, and states and territories setting out the framework for joint funding and policy in relation to health and health care, including aged care.

Eight state and territory health strategies would be developed and agreed bilaterally between the Commonwealth and each state and territory, with national incentive payments tied to achieving key initiatives within each state or territory strategy, in line with the national strategy.

It would be expected that key elements in the national (and each state and territory) plan would be the reforms proposed elsewhere in this report, including, for example:

- integrated primary health care catering for people with chronic and complex care needs, joining up Commonwealth-funded general practice and previously state-funded community health services (see Chapter 2);
- a single national system of regulation (of professions, of services, and of public health) (see Chapters 1 and 14, and Section 12.3);
- a national initiative to encompass oral health (see Chapter 11);
- improved provision of mental health services (see Chapter 10);
- a nationally consistent approach to activity-based funding of public hospitals for admitted and non admitted services to improve efficiency and access (see Chapter 4);
- a clear focus and funding for improved Indigenous health (see Chapter 8); and
- national audit and evaluation and reporting of policy and service delivery against agreed benchmarks (see Section 12.3).

■ An overarching National Health Strategy would be developed and agreed by the Commonwealth, and states and territories

In particular, it is proposed under this option that the Commonwealth would pay per patient episode, a proportion – say, 40 per cent – of the efficient cost of delivery of admitted patient care in hospital and of care in a hospital emergency department. Episodes of care would be classified and paid for using casemix classifications such as Australian Refined – Diagnosis Related Groups (AR-DRGs) for admitted acute care episodes, the Casemix Rehabilitation and Funding Tree (CRAFT) or Sub-acute, Non-acute and Palliative care (SNAP) classifications for sub-acute care and rehabilitation, and an appropriate casemix classification for emergency department episodes.

The total volume of services funded by the Commonwealth in this way would be open ended, as it is with medical and pharmaceutical benefits. The limit on total outlays would be the level of expenditure each state or territory would support to pay for the balance of the cost of hospital treatment. In this way, the Commonwealth contribution for public hospitals would be transparent while accountability for the total volume of services would rest unequivocally with states and territories. States would continue to bear the cost of any inefficiency in delivery, and of meeting the majority of the cost of admitted patient care, thus ensuring rigorous review of additional services as part of state and territory budget processes.

The Commonwealth would also fund 100 per cent of the costs of non-admitted hospital outpatient treatment (other than emergency department care) using a casemix classification such as the Victorian Ambulatory Care System (VACS). The volume of these payments would not be open ended. Instead, the Commonwealth would negotiate activity-based budgets for hospital outpatients with each state and territory under the bilateral agreements.

### *Option A – discussion*

Continuing to have both levels of government involved ensures that the existing advantages of the accountability of states and territories to their own populations are retained, and that the potential diversity and innovation that comes with state involvement continues.

This approach also directly strengthens the provision of integrated care by making funding and policy for all non admitted care – apart from emergency department care but including hospital outpatient care, primary health care and community health services – the responsibility of the Commonwealth. It also creates incentives for the Commonwealth to shape these programs with regard to the impact on people’s need for emergency department and admitted hospital care, as the Commonwealth will also be liable to make a payment for each and every episode of admitted and emergency department care:

- To the extent that people present to hospital for conditions that could have been prevented by greater investment in prevention and primary health care, the Commonwealth will have a direct incentive to address these.
- To the extent that older people remain in hospital awaiting aged care, again the Commonwealth will have a direct incentive to address this, as it will pay a significant proportion of the cost of caring for such people in hospital.

The Commonwealth payment will be based on the efficient cost of delivery as determined by costing of hospital episodes across all hospitals, public and private

■ The use of a partial, per case payment from the Commonwealth for each admitted patient episode will also serve to drive improved efficiency in the delivery of these most expensive health care services, as the Commonwealth payment will be based on the efficient cost of delivery as determined by costing of hospital episodes across all hospitals, public and private. Hospitals that can operate at or below the efficient cost will do relatively better than those that do not, unless states and territories choose to underwrite less efficient services through their component of the total funding.

A model of funding for public hospitals under which the Commonwealth pays a defined benefit for each hospital service, for admitted and non-admitted patients, could substantially defuse the blame game by making plain the basis of the Commonwealth contribution, and by the Commonwealth’s approach not limiting the total treatments available: the level of services available to a state or territory population would be clearly seen to be the result of state or territory decisions.

The transfer of greater funding responsibility to the Commonwealth (and the associated adjustment of grants to states) also serves to reduce the vertical fiscal imbalance, with state responsibilities for health spending being more in line with their capacity to pay.

Both levels of government would be more directly exposed to hospital costs, and so would have a powerful shared interest in ensuring, as far as possible, that hospitals are used only for services that are best provided by hospitals.

The outcome of this should be greater cooperation between levels of government on initiatives such as hospital in the home, provision of step down and sub-acute care, provision of post-acute care, and effective linkage with primary health care.

This option means the states and territories would have significant and continuing responsibilities in the health sector, with a significant vested interest in prevention strategies to reduce potential demand for hospital care. This would thus ensure their continued interest in creating good links between the health sector and other sectors of their responsibility which impact on prevention (education, transport, urban planning).

Nevertheless, the continued involvement of two levels of government would still create some challenges for coordination of policies and programs. While the proposed approach substantially realigns and makes clearer the responsibilities of the two levels of government, there would be new boundaries across which there might still be some tension. For example, states and territories might maintain that levels of Commonwealth funding for outpatient treatments were insufficient, resulting in an increased need to admit patients for treatment, or that Commonwealth policies in primary health care were still not as effective as they should be in preventing avoidable hospitalisations. At least under this approach, the Commonwealth would have a direct share in the costs of hospitalisation and so would have a direct interest in understanding and addressing such issues.

Although this proposal involves a significant shift in responsibility to the Commonwealth, and requires development of a national payment system (at least for Commonwealth payments for hospital services), it involves less disruption to existing roles and responsibilities compared to the other options outlined here. The implementation and transition risks for this option are thus the least of our three options. Interestingly, for advocates of the other two options outlined below, adoption of Option A could be seen as a first or transitional step towards implementation of Option B or Option C.

■ Adoption of Option A could be seen as a first or transitional step towards implementation of Option B or Option C

## 12.5.2 Option B – Commonwealth solely responsible, with regional providers of some services

The second option we wish to canvass is a transfer of all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing and funding regional health authorities to take responsibility for former state health services such as public hospitals and community health services, in parallel to continued national programs of medical and pharmaceutical benefits and aged care subsidies. As we heard:

*A fundamental question is ... whether the divided responsibilities between Commonwealth and states can serve a functionally effective and coordinated national system ... it needs to be tested as to whether effective coordination will require over-riding Commonwealth authority.<sup>25</sup>*

25 Melbourne Monash Clinical Working Group (2008), Submission 112 to the National Health and Hospitals Reform Commission.

### Option B – key features

The Commonwealth would take on the functions (and presumably many of the staff) of current state health departments including funding, regulation and governance of:

- public hospitals;
- community health services including community mental health services;
- patient transport;
- alcohol and drug services;
- sexual and reproductive health services;
- child and maternal health services;
- school and public dental services;
- health promotion and prevention programs;
- public health protection services; and
- ambulance services

Option B requires agreement to transfer substantial funding (almost \$24 billion) from states and territories to the Commonwealth

■ Option B requires agreement to transfer substantial funding (almost \$24 billion) from states and territories to the Commonwealth. In 2006–07, Option B would have entailed transferring from the states to the Commonwealth:

- the responsibility for administering annual recurrent expenditure of about \$20.3 billion comprising:
  - \$14.3 billion for public hospitals;
  - \$3.6 billion for community health services and other non-institutional expenditure;
  - \$1.2 billion for patient transport including ambulance services;
  - \$0.7 billion for public health
  - \$0.5 billion for public dental care; and
  - annual capital expenditure and capital depreciation of about \$3.5 billion.

Existing institutional and legislative frameworks from each state and territory (for example, regulation of ambulance services) would be replaced by a national, Commonwealth institutional and legislative framework. So, instead of eight sets of legislative or organisational frameworks for health services, there would be single national legislation and a single national approach.

It is proposed under this option that the Commonwealth would establish regional statutory authorities with responsibility to plan and operate public health services for that population. That is, these authorities would take over most of the formerly state government funded health services within each region. Another approach would be for states to either establish these regional authorities themselves or, in fact, for states to become the regional authorities, but with policy and funding being a Commonwealth responsibility. (The latter situation might occur in a small state such as Tasmania). This is essentially the model for universities.

Under Option B, existing national payments (such as the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and aged care) would be retained. The major elements of the regional budget would also be determined on a national basis – for example, using a national approach to activity-based budgets for regional hospital services.

Population health initiatives requiring a state or national focus, such as tobacco regulation or social marketing campaigns, would be managed at the national level, although regions might be enlisted in aspects of national initiatives.

Education and training would be a national program, through the National Clinical Education and Training Agency as briefly outlined earlier in this chapter, with specific funding to regions based on training places provided and training outcomes achieved.

The focus of regional authorities would be on planning, commissioning and operating the integrated provision of health services for which they are responsible within their regions. This could involve linkage to private and not-for-profit providers of health and aged care services in that region. Regional performance in service delivery and minimum requirements such as service accreditation would be monitored nationally.

Regions would be required to develop three to five year regional plans, with clear involvement from health services and the region's community. These plans would identify local priorities for service development and health improvement. The Commonwealth would negotiate three-year funding agreements with each regional authority detailing the elements of proposed regional plans for funding.

New functions for the Commonwealth would probably include:

- determination and negotiation of annual budgets for regions covering public hospitals and other former state government funded health services within scope:
  - Commonwealth would move to national standard activity-based budgets for public hospital services; and
  - would be likely to adopt simpler funding agreement approaches for smaller services.
- a variety of arrangements might also be used to share financial risk with regions, including:
  - fixed or maximum total payments (that is, grants) to regions, with regions taking the risk that they will have to treat more people than anticipated; and
  - tapered payments, where the Commonwealth shares with regions the cost of additional services above a specified level by paying additional amounts for the additional services, but at a diminishing rate.
- the Commonwealth would also set rules around maximum user charges for types of services – these would presumably reflect, at least initially, current rules.
- planning for all services with community participation and with services and providers involved through the regional authorities and the Divisions of Primary Health Care.
- priority setting and funding for major capital works projects.
- performance monitoring across all health services, standardised nationally.
- quality standards and accreditation requirements, standardised nationally.

Industrial relations would likely be devolved, as is currently the case in areas of existing Commonwealth responsibility including aged care, Aboriginal and Torres Strait Islander health services, and services for veterans and their families.

This option does not, of itself, require changes to private health insurance or existing universal programs (medical and pharmaceutical benefits and hospital treatment as a public patient). However, the Commonwealth would be exposed to a different range of pressures that might shape its policies on these issues.

### **Option B – discussion**

Option B would substantially resolve the blame game between governments in regard to health. It would make one government squarely accountable for all of health and health care. It is likely that there would continue to be some tension between regional health authorities and the Commonwealth around the adequacy of funding to support the regional health services, and possibly also around the boundaries between the continued national programs (Medicare Benefits Schedule and Pharmaceutical Benefits Scheme) and those funded through a regional budget.

■ Option B would substantially resolve the blame game between governments in regard to health

However, there would be no doubt as to which government was responsible for the health system as a whole. The mechanisms we propose (especially the use of activity-based funding) should make the basis of funding clearer, and significantly reduce incentives for cost shifting between national programs and regionally-funded services.

We expect that the Commonwealth would move to resolve many of the inconsistencies and competing arrangements that are a feature of the current situation, leading to an improved capacity to integrate care around people's needs. For example, the provision of pharmaceuticals in and out of hospital could be sensibly aligned. Similarly, there would be strong incentives on the Commonwealth for primary medical care in hospital emergency departments and in the community to be better aligned, and former state government funded and run community health services could work directly with private GPs.

The Commonwealth would have to acquire expertise in all aspects of the health sector to underpin its broader role, which in itself should enable better national policy development across all aspects of health and health care.

The establishment of regional health authorities would also facilitate more coordinated delivery of care, fostering relationships not only between the services for which a regional authority is responsible, but also with other services, including privately-provided services within a region, including through the Divisions of Primary Health Care. The regional health authorities should also, through community representation, provide a mechanism for people to have a greater say in the governance of their local health services.

We believe this option could be an improvement on current arrangements in terms of ensuring a rational allocation of funds across the various programs. It would contain little or no incentive to cost shift and ensure a greater focus across the system on effectiveness of care and innovation, with some flexibility in the use of funding by regional health authorities.

However, Option B requires a major shift of funds and management expertise from the states to the Commonwealth, with all the attendant risks of major change. There is a risk of loss of the diversity and local innovation and adaptation that are a feature of state involvement in health care presently. However, new regional health authorities could have the potential to foster local innovation.

This option potentially weakens community and electoral accountability and responsiveness by having only the national level of government involved in health and health care. Arguably, state and territory governments are more responsive to the views of their electorate than a national government that has to balance the interests of Perth or Launceston against those of Sydney or the Gold Coast. It also separates health from other state government managed programs such as housing, community services and education, with a consequent loss of opportunity to integrate health care with those programs, and a reduced incentive for states to shape those programs to contribute to improved health outcomes.

There is also a risk in having a single regional body for each region that it will be vulnerable to 'provider capture' and/or that its role as a major supplier of many health services will lead it to be unresponsive. This may need to be addressed by creating institutional arrangements at the regional level that ensure a strong public voice, with separate articulation of interests as between the regional body and the community (for example, through the creation of a separate regional community health council) to ensure there is clear accountability to the local community.

Alternatively, there could be strong, direct representation of the community on the regional body, possibly through inclusion of one or more members appointed by the elected local government or appointing suitably qualified member(s) of the community. Consistent with the principles of good governance in a professional board, either of the above membership options, though, would require the board members to act in the interests of the regional health authority, not their own constituencies.

### 12.5.3 Option C – Commonwealth solely responsible, with competing health plans responsible for providing cover for most services

The third option we wish to canvass is to transfer all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing a tax-funded community insurance scheme under which people would choose from multiple, competing health plans. These plans would be required to cover a mandatory set of services including, for example, hospital, medical, pharmaceutical and allied health services.

#### *Option C – key features*

This would see a transfer of responsibility for funding and policy setting of all health services from states and territories to the Commonwealth, with the Commonwealth then delegating purchasing responsibilities to competing health plans. It would be expected that the majority of such plans would be private or non-government, although there would be scope to also have a government (Commonwealth or state) owned and operated health plan(s).

This approach of tax-funded cover through competing health plans is generally termed ‘social insurance’ to distinguish it from private health insurance (where people pay directly out of their own pockets to buy insurance) and public insurance (where governments use taxes to meet most of the costs of health services directly). Social insurance is one of the earliest forms of universal health cover still used in many Western European countries.<sup>26</sup>

Under this approach, the Commonwealth would establish a national regulatory framework for the operation of the health plans. This might include:

- prudential requirements;
- scope of health services to be covered (and possibly defined benefits and methods of payment such as use of a common schedule of items for medical services, use of Diagnosis Related Groups for payment for admitted patient services); and
- provision of subsidies only for pharmaceuticals evaluated as relatively cost effective by the Pharmaceutical Benefits Advisory Committee.

Aspects of the regulatory regime (for example, prudential requirements) would be similar to those for current private health insurance, but with health plans having responsibility for all health cover for their enrolled members.

People would be entitled to enrol with their health plan of choice, and every Australian citizen and permanent resident would be required to be enrolled with a health plan. In this regard, social insurance for health care would be similar to compulsory superannuation with fund of choice.

Health plans would have no right of refusal – that is, no right to refuse to have an individual as a member of their plan. They would be required to offer cover to rural, regional and remote people on the same basis as to those living in cities.

■ Social insurance is one of the earliest forms of universal health cover still used in many Western European countries

26 M Foley (2008), A mixed public-private system for 2020, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

The Commonwealth Government would raise funding through taxation<sup>27</sup>, via an identified, transparent health levy to meet the full costs of the social insurance scheme. This funding would be allocated to a health plan of the citizen's choice by the Commonwealth Government based on the 'risk adjusted' membership profile of each plan. Risk adjustment would be done actuarially, to reflect the expected relative spending on people by characteristics not under the control of the plans. Hence, the share of the total tax pool allocated to a health plan would be adjusted prospectively to reflect the relative cost of all people's past use of health services adjusted for age, sex, location and health status (including existing conditions), and any other factors found to be relevant.

Had such a scheme operated in Australia in 2006–07, to cover 69 per cent of health care expenditure (as did governments in that year under current arrangements), the average, annual payment per capita to a health plan would have been around \$3250. This would have ranged from a low of perhaps a hundred dollars or less for some people, to many tens of thousands of dollars for other people, based on their characteristics as taken into account in the risk adjustment model used. All government expenditure on health and health care in 2006–07 equated to about 14 per cent of taxable income. So, the levy to fund the scheme fully to provide the same coverage as under current arrangements would also be around 14 per cent of taxable income. This is not an additional tax – rather, it is just identifying the component of taxation that already goes to health and health care. Actual total taxation including the levy would be no higher, provided the total funding under the scheme is the same as is met by governments currently.

Under Option C, health plans would be required by regulation to cover essentially all of the same services covered under existing universal and state government schemes. However, they would be free to strike their own arrangements with providers, including entering into preferred provider arrangements. Co-payments for mandatory coverage could be limited by regulation.

Health plans and/or third party insurers would be permitted to offer separate additional tables of cover for an additional premium, but would not be able to use such additional premium revenue to top up the government allocation for mandatory service delivery.<sup>28</sup>

Large health service provider organisations, or networks of providers, may be permitted to offer health plans, provided they meet the same requirements as all other health plans.

As with Option B, population health initiatives requiring a state or national focus (such as tobacco regulation or social marketing campaigns) would probably continue to be managed by governments at the national and state level. However, health plans might be enlisted in promoting aspects of national initiatives to their members. Education and training of health professionals would also be a national program, with specific funding to health services (independent of health plans) for training provided and training outcomes achieved.

---

27 Two long-standing social insurance regimes, in France and Germany, raise a large proportion of their revenue through employee and employer contributions. In both cases these contributions are supplemented by public funding from taxation. In effect the employment contributions are a tax, and arguably raising the funds through tax is more efficient. In addition, if funds are raised through tax, then the government can ensure that the distribution of funds to health plans is directly risk-adjusted, rather than relying on reinsurance arrangements to equalise membership risk between plans at the margin. Also raising funds through taxation simplifies providing contributions for those not in work, including retirees. That said, in a scheme very recently introduced in the Netherlands, half the funding is raised through tax and half the funding for adults is raised from direct premiums according to the health plan they choose. This is seen as providing people with a clearer understanding of the costs of their choices. However, it requires a complementary tax rebate to offset the differences in people's capacity to pay. The Netherlands scheme also involves a high degree of reinsurance (risk adjustment based on actual claims experience, after the event) which can undermine incentives for health plans to be efficient purchasers of the most effective services. For further information on the Netherlands approach, see J Stoelwinder (2008), *Medicare Choice? Insights from the Netherlands health insurance reforms* (Australian Centre for Health Research), at: <http://www.achr.com.au/pdfs/MedicareChoice.pdf>.

28 It is worth noting that in both the French and German schemes, social insurance does not cover the full cost of health care. People are permitted to take out additional cover, privately funded, to pay the gap. Poorer people are provided with such additional cover funded by the government from taxation. While such cover ensures no cost barriers to people's access, it increases the likelihood that people will make greater use of at least some forms of health care, and that providers will feel less constrained in increasing their charges. In 2005, using OECD data, health care represented 11.1 per cent of France's GDP, 10.7 per cent of Germany's GDP but only 8.8 per cent of Australia's GDP (Australian Institute of Health and Welfare 2008, Australia's health 2008, Australian Institute of Health and Welfare: Canberra). Conversely, expenditure on out-of-pocket costs as a share of GDP in 2005 was 1.4 per cent in France, 2.4 per cent in Germany and 2.8 per cent in Australia (Australian Institute of Health and Welfare 2008, Australia's health 2008, Australian Institute of Health and Welfare: Canberra).

Social insurance separates governments from direct payments to, or funding of, health services for health care. In general, European social insurance has also operated as indemnity insurance, similar to the medical and pharmaceutical benefits schemes in Australia. That is, health services charge people, who are then reimbursed for around 70 per cent of the costs by their health plan. This means that even publicly owned and operated health services operate more like private health services, raising revenue through charges, and being paid according to the work they do (i.e. activity-based payment), rather than operating on fixed budgets. Reputedly, and not surprisingly, waiting lists for hospital services, for example, are not an issue in the way that they are (or have been) in budget-funded systems such as the UK and Australian public hospitals.

### *Option C – discussion*

Key strengths of social insurance are the incentives for health plans to be responsive to the needs of their members and to purchase services in an integrated way to meet those needs. Accountability is strengthened by people's capacity to change to another health plan if they are unsatisfied with the one with which they are currently enrolled.

This approach also provides competitive pressures for efficiency, with health plans having an incentive to maximise the cover they can offer to attract more members while maintaining or improving their operating margins.

The competitive pressures in this approach could also drive innovation in funding and purchasing of services, and in health services seeking to attract members of health plans to use their services and so maximise their revenue. Health plans also have an incentive to take initiatives that will improve the health of their members to lower their expenditure on health care and to purchase health services with a focus on high quality performance and outcomes.

The use of taxes to fund health plans ensures that contributions are equitable with the better off contributing more. Moreover, the transfers from tax to the health plans are based on the person's relative needs, independent of the level of tax they pay.

Potential downsides with social insurance include transaction costs. Relative to Option B, the social insurance option would involve health services having to negotiate arrangements with many different health plans. There may also be additional complexity for consumers trying to establish which health plan will best meet their needs. Again, relative to Option B, it would be expected that a greater share of total spending would go on marketing as health plans would compete for members through advertising, sponsorships and similar activities. There would be potential loss of economies of scale currently achieved in the administration of the major national programs.

This option also requires the greatest departure from existing approaches, with all the attendant risks inherent in such a fundamental change.

Careful consideration is also required as to how social insurance would fit with private insurance. It is suggested that private health insurance would continue to have a similar role as it does in the current system – providing cover for services not included in social insurance and for levels of amenity not covered by social insurance.

## Reform direction 12.3

We propose to give further consideration to the following three options for reform of governance:

- (A) *Shared responsibility with clearer accountability.* Retain both Commonwealth and state and territory involvement but re-align responsibilities between them, with the Commonwealth:
- becoming responsible for all primary health care funding and policy;
  - paying to states and territories a significant proportion per episode of the efficient costs of inpatient treatment and of emergency department treatment (set at, say, 40 per cent); and
  - paying, using a casemix classification, 100 per cent of the efficient costs of delivery of hospital outpatient treatments.

This would be established through a National Health Strategy covering all health policies and programs, underpinned in turn by eight bilateral agreements between the Commonwealth and each state and territory.

- (B) *Commonwealth to be solely responsible for all aspects of health care, delivering through regional health authorities.* Transfer all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing and funding:
- regional health authorities to take responsibility for former state health services such as public hospitals and community health services, in parallel to continued national programs of medical and pharmaceutical benefits and aged care subsidies.

- (C) *Commonwealth to be solely responsible for all aspects of health and health care, establishing compulsory social insurance to fund local delivery.* Transfer all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing:
- a tax-funded community insurance scheme under which there would be multiple, competing health plans for people to choose from, which would be required to cover a mandatory set of services including hospital, medical, pharmaceutical, allied health and aged care.

## Concluding comments

We welcome feedback on each of these three options to improve the governance of Australian health services.