NATIONAL HEALTH REFORM AGREEMENT FIRST NATIONS SCHEDULE

QUESTIONS AND ANSWERS (Q&A)

National Health Reform Agreement (NHRA) – scene setting and scope

Q1: How does the NHRA operate and what services does it fund?

- The NHRA is an Intergovernmental Agreement between the Commonwealth and all states and territories signed by First Ministers in 2011. It has been amended twice, in 2017 and 2020.
- The NHRA funds services done by public hospitals, or commissioned by public hospitals.
- The NHRA provides funding for public hospital services through several mechanisms including:
    - Activity Based funding – the predominant method for funding hospital services, including acute admitted care, emergency care, non-admitted care;
    - Block funding – for services including small rural hospitals, mental health, teaching and research; and
    - Public health funding.
- In 2022-23, 38 million public hospital services and $64 billion captured by the NHRA (Combined Cth and state/territory funding contributions).

Q2: What did the MTR recommend?

- Rosemary Huxtable AO PSM conducted a mid-term review of the NHRA in 2023 for Health Ministers.
- The Review found the introduction of Activity Based Funding for public hospitals generated efficiencies, as well as accountability and transparency, but in other ways the NHRA had mixed success and the level of enduring reform that was anticipated has not been achieved.
- The Review recommended the next NHRA addendum include an additional schedule focussed on improving the health of First Nations people through the Closing the Gap commitments (Rec 38).
- The Review recommended the First Nations Schedule should include at a minimum:
    - A **shared commitment to Closing the Gap**, working in partnership with First Nations people.
    - **Specific actions to close the health gap** with accountabilities assigned and performance assessed against agreed milestones, including cross-cutting targets.
    - A shared commitment and requirement to work with ACCHOs and local communities in the design and commissioning of services and transitioning of services to community-control.
    - A shared commitment to **Cultural Safety** in health service delivery with agreed measurement and reporting, including patient experience indicators.
    - A shared commitment to embed appropriate **governance of Indigenous data holdings** held by all levels of government.

Timing and process questions

Q3: What is the timeframe for developing the First Nations Schedule for the NHRA?

- National Cabinet tasked the negotiation of the next NHRA Addendum to Health Ministers with the aim to finalise the 2025-2030 Addendum agreement by mid-2024.
- However it is apparent that some Schedules of the NHRA may need to finalised over a longer period. This is certainly the case with the First Nations schedule – the priority is that it is done right, ie through codesign with First Nations stakeholders.

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- This Roundtable [22 March 2024] is our first opportunity to talk about the Agreement and hear from the First Nations health sector what the key priorities should be for the schedule.

Q4: How will First Nations people be consulted?

- The discussion at this Roundtable is the first step in the consultation processes that will lead to the development of the new First Nations schedule
- We know we can't develop a draft First Nations schedule without First Nations people. As announced by Minister Butler, we are committed to co-designing the schedule with First Nations people.
- We already have some structures in place which could be used to lead this co-design process, including the National Aboriginal and Torres Strait Islander Collaboration which has members from all state and territory government health departments as well as one First Nations stakeholder from each jurisdiction.
- We are open to ideas about the best ways to work with First Nations people to make sure we get this right.

<u>If pushed on exact models</u>

Preferred models for the Commonwealth are:

- Use a group with First Nations stakeholders and some NNG members (equal representation). The Collaboration may fit this.
- Allow some First Nations stakeholders to sit on NNG in a special meeting/s focussed only on the Schedule
- Have one or more First Nations stakeholders on NNG for the whole process (less preferred given the large amount of negotiation related to other matters)

Note that ultimately the NHRA, including the First Nations schedule, will be an agreement signed by the Prime Minister, Premiers and Chief Ministers.

Funding questions

Q5: What does the current NHRA include in relation to First Nations people?

- The current NHRA acknowledges the shared commitment of the Commonwealth and States to work in partnership with Aboriginal and Torres Strait Islander communities in closing the gap through the [COAG]-agreed agenda. However there is little else in the current agreement to advance this agenda.
- The Activity Based Funding formula that underlies NHRA funding includes a range of "loadings" which increase the funding for certain services, including those in remote areas and those for First Nations patients.
- **6.9%** of Activity Based Funding in 2021-22 went to services delivered to Indigenous patients. The proportion for block funding and COVID funding is not known, though block funding may be even higher.

Background:

- The ABF loading for First Nations patients is 4%. This sounds low, and may be brought up.

- The 4% figure is calculated from the hospital cost data, and reflects the additional costs for First Nations patients that are not explained by other factors in the calculation, such as remoteness. The 4% loading would be higher if these adjustments had not already been applied in the calculations.
- It would be possible to modify the order in which loadings are applied, leading to different loading factors for services to First Nations patients. This would have impacts on state and territory funding under the NHRA.

Q6: Why can't a proportion of NHRA funding (e.g. 3% nationally) be quarantined, or set aside, to be provided for services for First Nations people?

- The NHRA recognises state and territory governments as system managers for public hospitals, which includes responsibility for making decisions around the purchasing, or commissioning, of public hospital services.
- Within this framework the Commonwealth makes a funding contribution to each of the public hospital services purchased, or commissioned, by the states.
- The majority of funding disbursed under the NHRA is paid as Activity Based Funding (ABF).
- The existing pricing framework incorporates an Indigenous adjustment for episodes where the patient's Indigenous status is identified. This is intended to account for legitimate and unavoidable costs in the care of First Nations patients.
- In 2021-22, 6.9% of NHRA Activity Based Funding went to services delivered to Indigenous patients.
- The mid-term review:
    - Reflected feedback that this pricing framework and the Indigenous does not adequately reflect the cost of care that objectively should have been sought or provided.
    - Noted here is a place for the national funding model to better resource the services required to address the gap between Indigenous and non-Indigenous health outcomes.
    - Recommended the next NHRA Addendum detail minimum requirements for how the Commonwealth and State and Territory health departments, PHNs, LHNs and ACCHOs will work together on joint planning and commissioning.

Q7: How much extra funding will be made available to action the First Nations Schedule?

- There is not currently a budget amount set aside for the First Nations Schedule.
- It is important that the First Nations Schedule is codesigned in partnership with First Nations stakeholders so it includes the right actions and reforms to improve health outcomes for Aboriginal and Torres Strait Islander people.
- The Commonwealth has committed to provide significant new funding as part of the NHRA Addendum.
- On 6 December 2023, National Cabinet agreed changes to the Commonwealth's NHRA funding parameters that will increase Commonwealth funding (an increase to Cth Contribution Rate to 45% over 10-year glide path and increased funding cap).
- The scale of the additional investment by the Commonwealth is estimated to see many extra billions of funding distributed through the NHRA over 5 years.
- National Cabinet instructed Health Ministers to negotiate the NHRA Addendum to embed long-term, system-wide structural health reforms, including considering the NHRA Mid-Term Review findings.
- The reforms will focus on the entire health system and move towards a more integrated, equitable, efficient and sustainable system.

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Strategic questions

Q8: Why is a dedicated First Nations schedule within the NHRA Addendum important? What is its purpose and what will it achieve

Embedding a First Nations Schedule in the NHRA recognises that all health services have a responsibility to deliver culturally safe care to Indigenous people.

- The new First Nations schedule will ensure the NHRA's whole of system initiatives include a focus on achieving the priorities and targets expressed in the:
    - National Agreement on Closing the Gap
    - National Aboriginal and Torres Strait Islander Health Plan 2021 – 2031 (Health Plan)
    - National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021 – 2031
- First Nations people will benefit from all of the NHRA reforms eg more flexible funding and workforce arrangements and stronger governance will enable better connections between primary care, hospitals, aged and disability care, and better access to integrated services in rural and remote areas.
- Integration within the NHRA will provide a pathway to ongoing funding arrangements for successful First Nations innovations and pilot programs.

Q9: How will the NHRA relate to other key First Nations agreements?

- The NHRA is being reframed as an overarching health system Agreement supported by a new whole of health system performance framework. The NHRA will cross reference other major agreements and reflect the priorities and targets of:
    - National Agreement on Closing the Gap
    - National Aboriginal and Torres Strait Islander Health Plan 2021 – 2031 (Health Plan)
    - National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021 – 2031

Delivery / Implementation

Q10: How will governments ensure ACCHOs are engaged as key participants in the delivery of services under the NHRA?

- The Mid-Term Review recommended the next NHRA Addendum should detail minimum requirements for how the Commonwealth and State and Territory health departments, PHNs, LHNs and ACCHOs will work together on joint planning and commissioning (Rec 7).
- This recommendation is an important consideration in our thinking, but we also need to hear from the ACCHO sector on the views for how this can, or should be operationalised.

Q11: Will there be a requirement for Health Departments, Local Hospital Networks and Primary Health Networks to engage with ACCHOs on joint planning and commissioning?

- The Mid-term Review makes strong recommendations regarding codifying governance arrangements between LHNs, PHNs and ACCHOs to strengthen relationships between service planners at the local level and support joined up care delivery.

- Defining the roles and responsibilities of ACCHOs in the NHRA will support greater engagement with LHNs and PHNs, including co-design of services.
- Policy options to support more collaboration and flexibility especially in thin markets are being considered in the NHRA negotiations.

Q12: Will local communities be bound to national programs or will we be able to maintain/get support for our own approaches that are working?

- The NHRA has a core principle of 'incentivising local diversity and innovation in the health system as a crucial mechanism to achieve better outcomes' (NHRA Clause 19b);
- NHRA negotiations are discussing the need for flexibility around local priority setting in all reform areas.

Q13: How will the NHRA Addendum ensure cultural safety in health service delivery?

- The Mid-term Review recommends developing new First Nations specific performance indicators, such as cultural safety and healthcare access, to support Closing the Gap reporting.
- The Review acknowledges culturally appropriate models of health tracking may be required.
- Performance reporting metrics, including in relation to cultural safety, will be developed as part of the NHRA work program.

Indicators and Data questions

Q14: What can the NHRA do to reduce racism in health services?

- The NHRA has potential to create and maintain culturally safe environments for First Nations workforce and patients by building 'cultural awareness and competence through governance, equitable funding arrangements, service delivery and workforce development, across all health care settings' MTR p112)

Q15: What are the specific indicators that will be included in the NHRA aimed at improving First Nations health outcomes?

- The Mid-term review recommends a future health system performance framework include outcome measures, including more consistent collection of patient reported outcomes and experiences, Closing the Gap indicators, access measures and indicators for cultural safety in hospitals. The need for engaging with communities on new indicator development is recognised.