

Our hospital reformation



On 3 March 2010 the Prime Minister announced a proposal for reforming the nation's hospital system.

By Sim Mead and Narelle Cameron.

IN SUMMARY AND WITHOUT ANALYSIS... WHAT DOES IT LOOK LIKE?

Funding changes

The Commonwealth Government funds 60 per cent of:

- The efficient price of every public hospital service provided to public patients.
- Recurrent expenditure on research and training functions undertaken in public hospitals.
- Capital expenditure – both operating capital and planned new capital investment.

This equates to a revenue-neutral effect for the states and the Commonwealth. Around one-third of the GST revenue currently provided to the states is redirected to a national hospital fund and paid directly to Local Hospital Networks (LHNs).

The Commonwealth Government acknowledges health costs will increase faster than GST growth therefore in the long-term the level of investment required is above and beyond the value of the GST retained. Any additional funding is provided consistent with the Commonwealth Government's fiscal rules including holding spending growth to two per cent in real terms.

Payments to LHNs from the Commonwealth are on the basis of activity-based funding, meaning 60 per cent of the efficient cost of the service. The unit price is determined by an 'independent umpire' and includes a series of loadings that adjusts the price for the most important patient and hospital factors and a series of cost weights that reflect the cost differences between different diagnoses and procedures.

States need to be transparent about their 40 per cent funding contribution using the same nationally consistent activity-based funding approach. They're also required to fund any amount over and above the efficient cost of a service as determined by the 'independent umpire'.

Activity-based funding is expected to lead to savings of between \$0.5 billion and \$1.3 billion per year. Efficient LHNs are able to reinvest savings in further innovation or more services.

Funding and policy responsibility is to be taken on by the Commonwealth for all primary care including that currently provided by the states. This includes some hospital outpatient services that are "primary healthcare equivalent" and more appropriately provided for in the community, for example physiotherapy outpatient services.

The Commonwealth takes over 100 per cent of the funding responsibility for all primary care services including those currently provided by the states. This includes community mental health services, drug and alcohol clinics and some "primary care equivalent services" that currently operate as hospital outpatient services, e.g. physiotherapy.

The Commonwealth Government reserves the right to proceed to a full funding takeover if the states do not agree to the plan.

Structural changes

Establishment of a National Hospital Fund which distributes directly to LHNs approximately 30 per cent of GST revenue.

An 'independent umpire' establishes the nationally efficient price for each public hospital service and also:

- Advises the government on appropriate timelines and path for transition.
- Determines the scope of the activity-based funding system.
- Makes binding determinations on cost-shifting and boundary issues between the Commonwealth and the states.
- Engages with clinicians on technical issues to ensure the efficient price continues to reflect the actual cost of

providing services and developments in best practice.

- Advises on the mechanism to provide the Commonwealth's contribution to teaching and research.

The Commonwealth Government requires states to create LHNs' small groups of public hospitals with a geographic or functional connection. They have an annual service contract with the state that sets targets for the amount of hospital service to be purchased as well as performance targets and benchmarks. They are state statutory authorities, typically comprising one to four hospitals and possibly more in regional areas.

In my opinion

The reforms announced so far are city-centric and do not address the issues confronting rural and regional Australia. An 'efficient' case mix funding model applied to the bush would make most hospitals non-viable. Details of how the government plans to buffer rural hospitals needs to be released urgently. Steady throughput of procedures which is the hallmark of case mix success cannot be achieved in small population centres.

The very considerable transport costs for transferring patients to diagnostic imaging and specialised care also need to be guaranteed and removed from assessments of efficacy.

Dr David Rivett, Bateman's Bay GP and Chair of the AMA Rural Reference Group

The Commonwealth Government wants LHNs to be established within current health department staffing levels and the states restructure their department/regional operations accordingly.

A professional Governing Council and CEO is provided for each LHN. Governing Councils include local health, management and finance professionals including local clinicians. The CEO is appointed by the Council and accountable to that Council. The Governing Council can remove the CEO and the State Minister can remove the Chair of the Council.

In cities LHNs are built around each principal referral hospital or specialist hospital and smaller city hospitals are incorporated in the LHN on the basis of logical links. In regions LHNs are built around each large regional acute hospital. States can decide whether to incorporate smaller regional and rural hospitals in these regional LHNs or create other LHNs.

State health departments specialise in system-wide service planning and performance management issues. Some functions, for example procurement, may be administered at state level. LHNs are the employers of staff but conditions of employment are managed by states.

State governments continue to own public hospital assets and be responsible for industrial relations policy and employment of the workforce. They work with LHNs to determine the range and number of public hospital services to be provided within their jurisdiction. States continue to decide where hospitals are located and manage capital planning arrangements for public hospital services.

Whether states continue to operate (as opposed to fund) some primary care services is a matter for negotiation.

National standards

The Commonwealth Government uses its position as the majority funder to impose strong national standards.

New targets are backed by explicit financial rewards and penalties.

Standards include:

- Access to emergency departments.
- Access to elective surgery.
- Access to local GPs and other health professionals.
- Financial performance and efficiency.
- Safety and quality, e.g. reporting of adverse events and hospital-acquired infections.

The Commonwealth works with states, clinicians and local communities to develop local performance standards and information useful for patients in evaluating the care they receive.

Transitional arrangements 2010 – 2011

- Commonwealth works with states to determine the financial transfers required.
- Commonwealth works with the states to conduct a stocktake of primary healthcare services to identify and cost services to be directly funded by the Commonwealth.

1 July 2011

- Commonwealth increases funding contribution to 60 per cent of recurrent expenditure on public hospital services, research and training and planned new capital expenditure. Payments made to state governments and LHNs where established.
- Commonwealth begins funding primary care services that are currently state-funded.

1 July 2012

- Commonwealth starts to progressively shift funding to activity-based funding paid directly to LHNs, starting with admitted patient services and progressing to emergency department and outpatient services.
- Commonwealth consults with states about how to give effect to funding 60 per cent of planned new capital investment.

1 July 2013

- Share of GST revenue to be dedicated to healthcare costs fixed. Commonwealth's contribution to future growth in health costs over and above the rate of growth in GST met from its budget. Funding to LHNs moves from an individual state price towards a national efficient price.

In my opinion

It is difficult to separate training and education from day-to-day work for doctors within the public hospital system. When the Federal Government commits to funding 60 per cent of training and education what does this actually mean? Will this be to fund new positions that provide education and support for junior doctors? Will this be to pay for seminars and training courses? Will this be to support TESL for staff specialists? The lack of detail about this aspect of the government's proposal is one of its major shortcomings.

The overall intention of the Federal Government's proposal is a step in the right direction and has the potential to create a fairer, more equitable system. It does, however, remain a predominantly administrative re-structure. What the hospital system – and health system in general – really needs is for insightful clinicians to be given authority to shake-up clinical practices that are out-dated, inefficient, or sub-standard. This has not been recognised by either state or federal governments as yet. Until it is, real progress will not be possible.

*Professor Brad Frankum,
Professor of Clinical Education
UWS School of Medicine and Dean
of the Macarthur Clinical School
and AMA (NSW) Councillor*

In my opinion

The reforms proposed, on face value, are a step in the right direction but as has already been said by many there is a lack of detail to the plan and other areas of significant concern. For example, activity-based funding may provide incentives towards providing services efficiently and reward hospitals for doing more of what they can do well. However, smaller hospitals and particularly those in rural and remote areas may be significantly disadvantaged under this system. While the proposal acknowledges this and plans to take such disadvantage into account it is yet to be seen how this will be done.

It needs to be recognised that no single model of governance will suit all areas and states. The smaller local area networks proposed in this plan would mean a significant re-organisation of health services. While these may work well in a state such as Victoria, those with larger geographic areas may be less suited to this model. In addition, the make-up of the local boards and the methods of appointment need closer scrutiny.

Finally, the funding of the plan lacks detail. The plan relies on the new activity-based funding model being able to deliver services more efficiently and therefore significant savings. It's not yet clear how these savings will be achieved if the plan seeks to also 'incentive-ise' activity and reduce waiting lists as surely more activity will require even more funding.

Associate Professor Brian K. Owler, Consultant Neurosurgeon at the Children's Hospital, Westmead and AMA (NSW) Councillor

Future announcements

The Commonwealth Government will announce additional reforms including:

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

In my opinion

We need to make sure education and training is well-funded and that with the increased numbers of medical students coming through that there are suitable placements for these students. At this stage it's all about waiting to see what the fine print will be. At the coalface we'd also like to see a reduction in bureaucracy and greater streamlining of training and education opportunities across the states.

It is a little too early to endorse the proposed reforms when we don't know what the nitty gritty or the fine print actually is.

Dr Kathryn Glasson, Hornsby RMO and Vice-Chair of the AMA (NSW) DIT Committee

