COMMENTARY

Can you provide our readers with an initial impression and response to the recently announced national health reform plan – *A National Health and Hospitals Network for Australia's Future* – and identify what you see as the major benefit and the major challenge in the adoption of the plan?

Given the announcement of the recent proposed health reforms we have taken the opportunity to ask key health policy leaders and commentators on their views of the benefits and challenges that such sweeping reforms will bring.

1. Too many unanswered questions

The main argument in favour of a single government funder for the health system is to promote a patient-oriented system. It rests on the increasing extent to which effective healthcare involves providing individuals with a mix of services over an extensive period, so that cost effectiveness requires the ability to shift resources easily between types of care. Such substitutability needs to be possible, at least to some degree, at a number of levels. At the national level, what a single government funder could help to do is to build the capacity to monitor the health of particular groups of high-risk patients (such as diabetics) and their care services and to provide support and guidance to improve cost-effective care.

It is also important to have some capacity to substitute resources across the system at much lower levels, to fill gaps (most obviously in rural areas but also in some outer metropolitan areas), to ease transition between services (to give more priority to rehabilitation and to involve GPs more in the overall process) and to offer convenient as well as lower cost services in place of the current over-reliance on hospitals.

A single government funder also offers the opportunity to rationalise co-payments, the relationship between public and private health insurance and the roles and efficiency of our public and private hospitals. The potential gains are probably of the same order as those from better allocational efficiency. The single funder may also lead to greater technical efficiency such as through wider use of activity-based funding of hospitals, but this was never the primary focus.

So how do the Rudd proposals stack up?

Frankly, not all that well on the basis of what has been revealed so far.

There is no explanation of how local hospital networks are to be linked to primary care or aged care, either locally or regionally.

Figure 11 in the document released in March is telling. [1] It purports to identify proposed roles and responsibilities, but the 'Regions' column is completely blank. The Prime Minister's discussions with the Australian Capital Territory Government also reveal confusion as to the role of the networks. Are they 'local' or are they regional? Are they providers only of acute care or responsible for broader health services? Will we see a primary care led system or a hospital dominated system?

There is also no clarification of how nationally the Commonwealth intends to take advantage of its direct involvement with paying for individual patient episodes in hospitals to improve cost effectiveness of care for the chronically ill and frail aged. With Medicare Australia now operating outside the health portfolio and no longer contributing significantly to its original 'health insurance' role (rather than just making payments), some new administrative arrangements are needed at the national level.

The National Health and Hospitals Reform Commission (NHHRC) [2] was also deficient in these areas. Rudd seems to be pursuing much of the NHHRC's 'Healthy Australia Accord' model, but with every indication that he does not like the NHHRC's preferred 'Medicare Select' model for the long-term. If that is not the long-term model, what is?

Regrettably, the NHHRC did not offer an alternative long-term model, rejecting the regional purchasing option (Option B) it described so poorly in its first report. [3]

Four years ago I set out in the first three issues of this Journal, my suggested model for the Australian health system based on the Commonwealth being the single government

funder. [4-6] This was a regional purchaser model, offering considerable opportunity to re-allocate resources between and within regions, as well as nationally. Importantly, I described in some detail funding, purchasing and providing responsibilities (and structures) at the national, regional and local levels, and outlined an implementation process. I noted it would be possible to move on from this model to a managed competition model (such as Medicare Select), but importantly the model also represents a long-term, stable structure with in-built flexibility to meet changing patient needs if managed competition is not favoured. Unlike the Rudd proposals, or the NHHRC's 'Healthy Australia Accord', it is not just a step towards something else.

That said, there is merit in Rudd's proposals, particularly if it is accepted that a direct move to a single funder is too risky. There are also weaknesses in many of the complaints by the Premiers.

The proposals do provide a basis for the Commonwealth to monitor the effectiveness of health services for the chronically ill, to improve primary healthcare and to address many of the gaps in the health system. Importantly, it opens the door for fundamental financial restructuring through its proposals to redirect GST revenue back to the Commonwealth to meet its increased health responsibilities. For these reasons I have been giving the proposals qualified support: they seem to be broadly in the right direction and there may be time over the two year implementation period to get the structure more nearly right.

The Victorian Premier has been focussing his attention on demands for extra spending by the Commonwealth. It is too easy to identify good things to spend more money on: the central reform issue is to develop a structure that is likely to encourage the most cost effective use of whatever monies are available. More telling criticisms by the Premiers concern the details of the proposed activity-based funding of hospitals, including who will bear what responsibilities.

Rudd may yet reveal satisfactory answers to the unanswered questions. But he must also be wondering now whether it would have been more sensible to go the full distance to a single government funder, and allow the Commonwealth to rationalise existing federal and state structures rather than allow the two to continue to co-exist and to continue to pull in different directions.

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2. Rudd's recipe for rude health

Something profound is happening in the Australian community when a debate at the National Press Club between the Prime Minister and Leader of the Opposition focuses on healthcare. An active interest is growing in public policy as a major instrument to achieve social goals and individual aspirations.

But Australian public policy problems have a habit of turning into conflicts over federalism, and this is dull fare. The immense imbalance in resources and responsibilities between the federal government (controlling most of the revenue) and the states (delivering services such as education and healthcare), transforms attempts to improve services into intergovernmental fiscal battles, leaving both sides locked in a circular game of cost shifting and finger pointing: are shortfalls in the hospitals the result of a lack of money (blame the Federal Government) or poor administration (blame the states)?

The Rudd reforms of healthcare have the virtue of confronting this administrative confusion. The Federal Government proposes to increase its share of hospital funding, capital and recurrent, from less than 40% to 60%. This adjustment is coupled with a resounding rhetoric of reform, promising a breach in the log-jam of federalism. The reality of the proposal falls short. The states are left, in Rudd's phrase, with considerable 'skin in the game' – their 40% share promises new versions of the old inter-governmental 'blame game'.

The second arm of Rudd's reforms involves a shift to more efficient pricing of hospital services. Victoria has been using a modified case mix system to fund its public hospital system – its apparent transparency has been taken, with remarkably little serious evidence, as proof that this should be the national model. Critics quickly invoked the diversity of the federal organisation of healthcare. Costs are quite different from state to state and even on a regional basis, making a

simple extension of the Victorian system impossible. Rudd has already promised to exclude smaller rural hospitals from the efficient price system. More concessions are likely to follow as regional and sectional interests mobilise, including academic interests in medical research and education in major hospitals. A national system could emerge, but with political compromises rendering the health economic 'efficiencies' illusory.

The largest hurdles derive from the most popular part of the policy, captured in the slogan 'funded nationally: controlled locally'. Pre-empting policies of the conservative opposition parties, Rudd moved to mobilise popular hostility towards the states and profound morale problems in many of the highly centralised state systems and promise effective, though undefined, control to local hospital-focused 'health and hospitals networks'. The proposal has won support from sections of the medical profession, including the normally hostile Australian Medical Association, to the consternation of sections of Rudd's Labor Party. Population health has an awkward future in such a fragmented structure.

So far Rudd's reforms have had a remarkably easy ride. Massive majorities for change in national opinion polls have reduced the opposition parties to carping negativity. Rudd's speeches commence with dire warnings about the crippling burdens of chronic illness in an ageing society; the policies that follow are focused thus far almost entirely on hospital funding. But much more is promised. Effective reform must avoid the quagmires of hospital finance and the sterile games of fiscal federalism. The roll-out of the entire federal health policy, informed by two years of consultation and expert deliberation, is likely to maintain public interest and, we may hope, lead to even better health and healthcare for all Australians.

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3. Bringing decision-making closer to the hospital?

The National Health and Hospitals Network plan is extremely short on detail. At the time of writing, we await more announcements, including some answers about primary healthcare and the relationship between hospital and non-hospital care. From the point of healthcare managers, one thing is clear and can be welcomed – staff of the 100 odd hospitals and health services consulted since July last year gave a strong message: we want decision-making to be closer to the hospital! Clinicians tell stories of hopeless delays in getting quite small local decisions made, and the many degrees of separation between them and anyone who has authority. The Leader of the Opposition has been hearing the same message, making this the one structural topic on which there is bipartisan agreement.

This is what the Prime Minister said early in his speech to the Press Club:

> These Networks will bring together small groups of hospitals in a local area, where local professionals, with local knowledge, are given the necessary powers to deliver better hospital services to their local community. (Prime Minister's speech to the National Press Club, 3 March 2010. www.pm.gov.au/node/6534.)

Are Australian hospital managers ready for a 180° turn? It's not so long ago that everything got centralised, in a great wave where decision-making authority was pulled right in to state health authorities around the country. It happened (in the 1990s and earlier this century) because governments wanted tighter accountability in a portfolio that always blows its budget. The belief that devolved governance (in the hands of semi-autonomous boards and their CEOs) was failing was based on budget deficits and some insubordination by hospitals wanting a bigger or more glamorous role.

Victoria was the only standout, keeping boards but reforming them twice – former Premier Kennett made bigger networks and more business oriented boards; former Premier Bracks made them smaller and reduced their autonomy. Victoria is now seen as the best performing system, although the evidence for this view is slim. On the other hand, there is no evidence that centralised governance has reduced hospital budget deficits, which continue relentlessly. So we observe the winds of change, and wonder.

Will the Rudd/Roxon plan work? That is impossible to say – there are too many unanswered questions. But there is one certainty worth noting. Change will happen, and for many reasons: people are convinced that reform is needed (93%

of respondents to a 'quick survey' on this question on the 'Your Health' website answered yes); the government has hung its hat on health reform (and Obama's just done it); and some states can't afford to operate health systems for much longer.

The major benefits will be increased funding and hopefully, the money following the patients, along with restoring operational autonomy to hospitals so they can get on with business a bit more responsively. The biggest challenges will be to retain the policy and administration skills that are currently in state health authorities; and to make sure that Canberra doesn't start to micro-manage instead.

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4. Hospital services: we know and can do better

Australia has been well endowed with health economics and policy professionals. Therefore, it is regrettable to see hospital services being treated like amateur hour on TV. The Federal Government's *A National Health and Hospital Network for Australia's Future* reflects on the skill and experience of those involved in its preparation. It illustrates approaches to health services in increasing centralised federal and state governments that try to micromanage the system with 'benchmarks', 'standards', financial 'budgets' and now 'efficient prices'.

The document proposes to continue to rely on the states to manage the system. So what is the advantage of the proposals to deal with 'fragmentation', 'blame-shifting', lack of 'cohesion', 'cost-shifting', 'increasing demand', 'innovations in technology', and 'increasing health costs' that 'outstrip revenue'?

The proposals deal mostly with structures and processes with abstract outputs and outcomes. First, the states give up about a third of their GST revenue, to make funding 'revenue neutral' (p.51). They set up hospital networks and manage them (p.64). The Federal Government pays 60% of the 'efficient price' of 'public' inpatient and outpatient services in public hospitals (p.27). The states are left with the responsibility for the rest of the 'efficient' and 'inefficient' costs of operation (p.35). Direct management of each 'Local Hospital Network' is given to a 'Professional Governing Council' and a 'Chief Executive Officer' appointed by the Council (p.63). Consumers have nothing to offer. Canberra oversees the system and gets the states to make these councils 'to operate efficiently' according to set 'standards' and 'service contracts' (p.61 and 64). The standards of clinical and other functions will 'evolve from the Australian Commission on Safety and Quality in Healthcare' (p.59). More consultants needed? The Feds 'will be alerted to poorly performing hospitals' and 'will require states to step in and fix these problems' (p.58 and 64). The hospitals will be funded by direct payment in accordance to the set 'efficient price'. In the case of dispute about the 'efficient price' and or 'scope of activity' a new and independent bureaucrat will be the 'umpire' and arbitrate (p.70). Et voila, there shall be one national non-fragmented system instead of eight different ones (p.28), 'reasonable levels of access', 'clinical safety', 'efficiency' (p.33) and 'a high quality health system that is sustainable into the future' (p.74). Are we that naïve? [1]

Let us start with 'fragmentation'. A major element in the fragmentation of the 'system' is between private and public services that involve clinicians, highly commercialised pathology and imaging services, hospitals, aged and extended care services, and many other elements in the private and public sectors. 'Local Hospital Networks' will not have the capacity to resolve this public/private aspect of fragmentation, as the 'hospital boards' of old did not. The Federal Government has no constitutional power to deal with private medical practitioners either. For instance, why are there only a few cases of 24-hour privately run services in public and private hospitals to serve drop-ins and those seeking medical care after private surgery hours? The proposed 32 GP super-clinics are unlikely to overcome this problem (on average: one clinic for 600,000 people). The same applies to governments' lack of action in ensuring quality aged/extended care in the private sector. This fragmentation is going to fade away with wishful thinking about GP services. Additional funds would help but it is not just funding. There is also fragmentation inside hospitals between clinical and ancillary services and due to professional boundaries that effect continuity and team approaches to hospital care. Similar management arrangements in the United Kingdom (in the good old days) to those proposed did not resolve and, at times, consolidated professional boundaries and a non-cohesive management. These are management issues that 'standards' and/or 'activity-based funding' are not well placed to deal with.

The document recognises that the states have faced substantial increases in hospital utilisation. However, it does not clearly explain that more than half of this growth could be attributed to other reasons than population growth and ageing. [2] The states are using funding caps on hospitals to keep use within their perceived budgetary constraints, when Canberra reduced its share of public hospital funding

from about 45% in 1995-96 to less than 40% in 2007-08. (p.290). These caps are one of the perceived factors leading to waiting lists and times and moral problems in hospitals. Canberra proposes to use activity-based funding to pay 60% of the 'efficient price' (p.27 and 33). It is supposed to provide incentives to the states and hospitals to improve efficiency and produce more with the same funding. The document states that activity-based funding could yield savings of $0.5-$1.3 billion per annum (p.50). The mid-point in the range represents about three percent of the operating costs of public hospitals. [3] If the problem in funding is only three percent, it is not as great a problem as it is made out to be. It is curious that state incentives are supposed to rise while their share of funding is implied to fall! Further, future spending will 'be constrained to two percent per year' in real terms (p.54). If demand continues to grow above two percent, either the states will have to fund it or hospitals will not be paid according to their activity: is it back to blame-and-cost shifting, and possibly constraints on admissions and long waiting times? Where is the future financial 'sustainability'?

The paper accepts that, in addition to funding, there are issues concerning the supply of doctors and nurses and proposes to have more trained. There is no doubt that the welcome increase in the proportion of female medical practitioners, often balancing practice and family formation, will continue to require more doctors per head of population. However, the training of more nurses does not address why so many leave the system and are not inclined to return. The observed prevalence of a bullying environment and other working conditions [4] are some reasons for the perceived scarcity of nurses, in spite of the large reservoir of trained people. Again, these are important waste and management issues that are not dealt with.

The document states that 9.3% of hospitalisations in 2007-08 were 'potentially preventable' (p.37). These were attributed to such conditions as lack of vaccination, dental problems, convulsions, epilepsy, dehydration, gastroenteritis, pyelonephritis, diabetes complications, chronic obstructive pulmonary disease and congestive cardiac failure. The authors of these estimates indicated that these were potentially 'avoidable if timely and adequate non-hospital care had been provided'. [5] Analysis of the data showed that socio-economic levels and relative remoteness were factors associated with rates of these 'avoidable' admissions. These issues involve, among others, the organisation and practice of private medical care (not just funding). They need to be addressed and are unlikely to be resolved by the 32 super-clinics, additional GPs, hospital networks or activity-based funding.

Canberra is adding to 'fragmentation' by the possible release of separate proposals for mental health, aged/extended care, primary healthcare and health promotion. A hurdle in getting most of the real issues dealt with is the impression that the problem is about who funds what. This is the easy part of the conundrum. Canberra's take up of a larger shared responsibility for hospital funding may have only a short-lived and cosmetic effect, and may result in considerable wasted time and resources. Hospitals often present the symptoms of unresolved problems elsewhere. That little attention is paid to mental and physical health promotion outside the medical sector is a major issue – the paper from Canberra indicates the failure of longer working hours (that may affect physical and mental health) leading to better policy work. The inept attempts to deal with the organisation and practice of private medical care and continuity of care among complementary services in the public and private sectors are rudimentary. Within hospitals there is reluctance to handle relevant management of clinical services. Yet another factor is the continuing mismanagement of human resources. These issues point to management rather than just funding questions. They suggest the need for more skilful managers and management in addition to any extra funding. Some of the proposals may prove useful such as more local management responsibility and the evolution of clinical standards. These could be considered needed but not sufficient conditions. Further, as far as the proposed composition of professional Governing Councils are concerned, it is useful to note that clinical training gives no assurance of hospital management skill, and financial skills are inadequate, and often inept, in handling human resources, the mainstay of healthcare. We know and can do better.

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5. It may be national and focuses on hospitals, but it is definitely not about health. . . .

As I read *A National Health and Hospitals Network for Australia's Future* I was transported back to my post-graduate studies at the University of Toronto. I can clearly see Dr Eugene Vayda standing at the front of the lecture theatre explaining how the Canadian healthcare system became expensive, because the national government gave money to the provinces for doctor and hospital care. [1] The Federal Government bribed the provinces to join up to the national health insurance scheme, but made the mistake of enticing them through the most expensive parts of the system. Dr Vayda emphasised that it was no wonder that health system costs were outpacing government revenues, when the federal government did not consider the needs of the population to provide a policy and funding package that was designed to keep people healthy in their community, but instead threw money at doctors and hospitals. This happened in Canada in the 1950s, and Canadians have spent the next 60 years trying to re-orient their healthcare system.

With the benefit of the knowledge of what has happened in healthcare systems around the world, why would the Australian national government use a policy approach that did not work in the 1950s to try to reform a 2010 healthcare system?

In my opinion the attention on GPs and hospitals in this reform process is misplaced, and healthcare costs will continue to rise. The 'national standards for a unified health system' set expectations for greater use of hospitals. Standards that focus on increasing access to public hospital care do not reposition the system from one of caring for the ill to ensuring health. There is clear evidence from organisations such as Kaiser Permanente that setting standards that require population health to improve results in a system that is better at meeting population needs [2] (as compared to our system, which is very good at meeting health professional needs). Even the United Kingdom has figured out that system standards should have something to do with improvement in health. The implementation of the PROMs (Patient Reported Outcome Measures) is slow but has the potential to refocus what is considered to be important for health. [3] Local 'hospital' networks have been tried in many countries, but the consensus is this model does not work: not surprisingly, expensive inappropriate hospital care increases in these structures. The government should be focusing on population health and encouraging local 'health' networks that are accountable for making a positive impact on the health of a community. The World Health Organization stresses the need for access to family- and community-oriented primary healthcare, supported by a flexible and responsive hospital system [4] (and not the other way around).

The goal of our system should not be to get more people into hospital, but to keep them out. The Commonwealth Government says that their pledge to take full policy and funding responsibility for GP and primary healthcare services in Australia will enable more care in the community. But we know that this will only work if there is equitable access. Maintenance of the current model with more than sufficient access to doctors and allied health practitioners in the cities, with long dusty kilometres between health professionals in the rest of the country, is not going to work. Perhaps instead of adding more health professionals educated and structured to meet the acute care demands of the past, the reform should focus on matching health professional skills with population health needs. [5]

I am concerned that despite the 'once in a lifetime' opportunity to make needed change, the Commonwealth Government is focused on ensuring a handful of trees survive, while the forests fall around them in chaos.

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6. Changes and challenges and reform: Australian National Health and Hospital Network

The Australian National Health and Hospital Network (ANHHN) proposes a fundamental redesign of funding and governance of the Australia's public hospitals. This shakeup promises to be the most significant undertaken of the Australian health system since the introduction of Medicare nearly 30 years ago.

The Federal Government's reform blueprint is based on a quantum shift in the current funding and administrative responsibility for public hospitals and primary healthcare that the Commonwealth and the states currently exercise. The reform package entails the conversion of the fragmented state-run health system to an integrated national system. The eventual aim is for closer Federal and state co-operation resulting in the creation of 150 local networks each running between one and five hospitals.

The reforms are designed to limit individual state control over policy and management of their respective health systems, which have increasingly been unable to meet the rising costs of healthcare delivery especially acute and sub-acute care. The reform proposals see a significant shift in Federal funding of health and hospital services. The ANHHN proposes that the Commonwealth claws back 30% of the GST payments, normally taken by the states. As a result of the reforms, it is proposed that the Commonwealth will assume 60% of the gross public hospital costs and out-patient services (up from the current 40%), and the states will each contribute the remaining 40%. In addition, the Commonwealth will continue to contribute mostly 100% of the costs of primary care and aged care services as they do at present.

A key element of the health reform is the establishment of Local Hospital Network (LHNs) groupings of up to five hospitals run by a chief executive and a governing council. LHNs will be responsible for the local needs and working collectively to address critical problems such as waiting lists and waiting times in emergency departments. However, this is an example of where 'the devil is in the detail.'

These LHNs will be obliged to work with local primary care providers. The funding arrangements and the integration between hospital and primary care services at a local level will be dependent upon the governance structure because in the past, resources have been largely directed to maintaining hospital services at the expense of primary care. The current outline of the networks is vague. This is particularly so in relation to how hospital networks will interact with local communities.

Under the reforms, the dependence on activity-based funding, or case-mix funding system, as adopted in Victoria and South Australia, will see a national roll out for all states. In terms of implementation, the reform proposals do not appear to be particularly well thought through but the reform affords the Labor party the opportunity to play to its strength and go to the polls with a health and hospital policy that purports to improve an ailing health system and has the aura of producing something radically different to what we have had in the past.

States and health professionals alike remain critical of the inadequate documentation and detail concerning how the health policy reforms will work in practice. With national elections to be held in the not too distant future, commentators have not been slow to suggest an underlying political agenda that is the driving force behind the reform proposals. In spite of these concerns, state Premiers are thought likely to sign up, albeit reluctantly, to the new health compact, not least of all by reason of the increasing difficulty of meeting spiralling health costs.

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7.Why the pressure is on to deliver on national health reform . . . .

My initial impression of the Rudd Government's plan, *A National Health and Hospitals Network for Australia's Future*, is that the Government has found itself in a political situation where it feels compelled to get 'runs on the board' in national health reform. The reasons are many and complex and they include the following considerations:

First, Prime Minister Rudd made a commitment prior to the 2007 election that he would 'end the blame game' and the shifting of costs and responsibilities between the states/ territories and the Commonwealth Government. In fact he went so far as to promise a referendum if he could not get the states to agree to a significant health and hospitals reform.

Secondly, the need to achieve significant reform became even more urgent and important when Rudd's proposed emissions trading scheme was blocked by the Senate prior to the Copenhagen Summit on Climate Change, in December 2009. The Rudd Government did not want to appear unable to achieve its reform agenda.

Thirdly, the pressure on Prime Minister Rudd increased even further when President Obama achieved significant reform in health insurance legislation in the United States of America in March 2010. This is of historic significance, as it extended healthcare to tens of millions of uninsured Americans, and achieved near-universal coverage. This won President Obama significant credibility both externally and domestically. So, for domestic, party-political and external reasons the pressure was on to be seen to deliver on national health reform.

So, my overall response is that the Rudd Government was under considerable pressure to reform the national health system in 2010. And it was left with a very tight time frame, basically before the 2010 May budget, to achieve this. The breakthrough came at the Council of Australian Governments (COAG) Meeting held in Canberra in April 2010 at which all the Labor states and territories agreed to a set of healthcare proposals. At the time of writing the Western Australia Government was opposed to the plan.

I will now identify the major benefit in the adoption of the plan. The major benefit of the healthcare agreement is that the public hospitals now have a more secure source of funding (with funding for hospital activities sourced 60% from the Commonwealth and 40% from the states). The incentive for cost shifting between General Practitioners and outpatients, and between hospitals and aged care institutions, is also reduced, as the Commonwealth has taken responsibility for funding primary care and aged care as well.

So, what is the major challenge in the adoption of the plan? The major challenge is that the Commonwealth agreed to allow the states/territories to administer the 90 or so Local Hospital Networks (LHNs). This means that the states will choose which hospitals to group into networks and will choose the council members who will oversee the LHNs, and hold them to account. This means that the Commonwealth does not have the power to implement the efficiency drives it seeks to achieve with the implementation of activity-based funding. [1] This is the major challenge. The Commonwealth is the major funder, but the states and territories still have the power to oversee the administration of public hospitals in their respective states and territories. The Commonwealth failed to secure sufficient power over the public hospitals it funds. Rudd's hospital reform plan is unlikely to achieve the value for money we have been promised.

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