

# Toward a road map for health system governance:

A discussion paper for NHHRC

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# Contents

A Governance Roadmap		1
2	Option A	3
	2.1	Leverage points of Option A 4
	2.2	Risks to Option A 6
3	Option B	7
	3.1	Leverage points of Option B 8
	3.2	Risks to Option B 9
4	Option C	10
	4.1	Key Leverage points of Option C 12
	4.2	Risks to Option C 12
5	Conclusion	14
Appendix A	Appendix: Achievement of Key Characteristics of Future Health System	15

# A Governance Roadmap

The National Health and Hospitals Reform Commission (NHHRC) has developed and presented three governance options in their Interim Report (December 2009) for discussion and consultation.

In simple terms, health system governance is defined by the NHHRC as the question of who should 'run' the health system. The NHHRC's discussion of governance focuses on the relative roles of the Commonwealth and state and territory governments for publicly funded health services. However, all three governance options would, to varying degrees, also have implications for the complementary role of private health insurance (PHI). The potency of the three options to address the problems of the Australian health system will also be influenced by the adoption of other recommendations in the report.

The three options are:

**Option A:** continued shared responsibility between governments, with clearer accountability and more direct Commonwealth involvement.

**Option B:** Commonwealth solely responsible, with regional providers of some services

**Option C:** Commonwealth solely responsible, with competing health plans responsible for providing cover for most services.

The objective of this paper is to explore the following:

- 1 How these options could function as a continuum or a series of phases for reform.
- 2 How the most productive use could be made of both public and private financing and service provision across these options or phases.
- 3 How each of the options or phases would realise the key characteristics the NHHRC is seeking for the future health system
- 4 Identify risks and benefits and risk mitigation of the various elements of structural reform in each option or phase.

## 1. Relationship of the 3 Options

The NHHRC's Interim Report comments that Option A could be a precursor to Option B or Option C. It is also possible to regard the three options in sequence as a road map for reform which over, say, 10 years could result in a comprehensive reform which integrates the total health system, involving both public and private, in a person centred network of complementary services.

There are a number of ways the three options could be approached as reform phases or a continuum:

- **Performance Based Sequence:** A structured time frame and outcome milestones could be agreed between the Commonwealth and the states and territories (and with other stakeholders as appropriate) on the basis that if certain key performance criteria are not met within agreed time frames then the next phase will be implemented to address these shortfalls.

This approach has particular relevance for moving from Option A to Option B. Bilateral agreements between the Commonwealth and the states could provide that if certain threshold improvements are not achieved or achievable within given timeframes, the Commonwealth will move to Option B and take full responsibility for policy and funding for public hospitals. Key trigger points could be:

- failure to achieve National Access Guarantees and National Access Targets for public hospitals
- inability of states to meet their share of the 60/40 funding split for public hospitals
- the clear demarcation of Commonwealth and State responsibilities does not support the building of bridges between acute care and primary/community based care.
- the states are unable to develop a comprehensive network of subacute services.
- **Cooperative, planned handover:** If it is accepted that, as the demand for health services increases and health expenditures continue to increase as a proportion of GDP, the vertical fiscal imbalance is such that States are not in a position to maintain public hospital systems in the long term then the sequence from Option A to Options B or C could be according to an agreed time frame. The Option A phase could allow time for the Commonwealth to ensure that primary care infrastructure is appropriately developed, while public hospitals would move to a more nationally organised system with standardised, transparent funding and a national performance reporting and accountability framework. Once these measures are in place and robust, a move to full Commonwealth responsibility for policy and funding of public hospitals would, arguably, be a much smoother transition.

There could also be overlap between phases. For example, there could be provision in bilateral agreements for a state or territory to opt to transfer full responsibility for public hospitals to the Commonwealth sooner rather than later.

- **Evolutionary Reform Model:** This approach has regard for a roadmap which potentially moves the system from A to B to C, but commits in the immediate term to a suite of structural reforms which are judged to create the greatest leverage for subsequent phases to evolve as a 'natural' progression. For example, the introduction of Divisions of General Practice by the Commonwealth in the 1990s has created a platform for the NHHRC to recommend extending this model to become Divisions of Primary Care, for regional planning and coordination of services. If these structures are successful, it may be natural for these Divisions to evolve into primary health care provider authorities or to merge with Regional Health Authorities under Option B. Similarly, the introduction of a shared 40/60 funding formula for inpatient services in public hospitals provides a mechanism by which the Commonwealth and states could agree to increase the Commonwealth proportion over time, moving progressively to full Commonwealth responsibility.

## Analysis of options

What follows is an option by option analysis of the key leverage points and how these are intended to address the shortcomings of the current system as identified by the NHRCC and to achieve the NHHRC's design principles for the health system of the future.

## 2 Option A

The key elements of Option A, including other relevant NHHRC recommendations, are:

- National Functions will be in place, in particular:
  - the national performance and accountability framework
  - the National Clinical Education and Training Agency.
- Overarching National Health Strategy agreed between Commonwealth and the states, including National Access Guarantees and Targets.
- Commonwealth takes responsibility for policy and funding of all primary care, including:
  - state community health services
  - development of Divisions of Primary Care for planning and co-ordination
  - development of Comprehensive Primary Health Centres.
- Commonwealth payments for public hospitals to be related to activity based outputs supporting a nationally consistent approach to funding public hospitals, including:
  - benefit payment of, say, 40% per inpatient episode
  - benefit payment of, say, 40% per Emergency department episode, plus standing overhead costs
  - incentive payments for identified performance targets
  - episode payments to include costs of routine capital
  - 100% payment on the basis of casemix for outpatient services.
- States to take responsibility to develop subacute services including:
  - activity and outcome based funding
  - national definitions and data sets
  - growth of inpatient and community services on the basis of agreed national targets
  - capex for new capacity to come from Health and Hospitals Infrastructure Fund.
- Specific service initiatives in place to meet gaps in services and access:
  - Denticare
  - Mental Health
  - National Indigenous Health Authority
  - equivalence payment for MBS in rural and remote areas where medical practitioners are not available.
- Universal payment programs remain in place:
  - MBS
  - PBS
  - Aged Care.

- Private health insurance and private hospitals continue in their current roles.
- Current level of private financing is maintained. The splits of Commonwealth and state inputs will shift with the Commonwealth taking greater funding responsibility. This will require adjustment of general tax revenue sharing arrangements between the Commonwealth and the states.

## 2.1 Leverage points of Option A

The benefits of Option A are well set out in the Interim Report, particularly the way in which Option A would address the “blame game” because the demarcation of Commonwealth and state responsibilities would be clearer and both levels of government would be on the hook for meeting the demand pressures on public hospital services.

The major leverage points of Option A which could drive further reforms in the direction of Options B and C are:

### **1. Transparency of all aspects of public hospital funding will place particular performance and funding pressures on states which could lead state governments and the community to support a move to Option B.**

Transparent, activity-based funding of inpatient, outpatient, sub acute and emergency department services will highlight variations in performance and will create strong pressures on both levels of government to address discrepancies, shortfalls and adverse variations.

The states will be under pressure to address discrepancies in efficiency and distribution of hospital services both between hospitals and in comparison with other States. States will also carry full responsibility for increasing the volume of inpatient and emergency department services to meet demand. These responsibilities will be onerous for the states. The question of whether state budgets, with their narrow tax bases, can address the inexorable demand pressures of health remains, even if the Commonwealth takes on the extra funding responsibilities of outpatients and community health. As the Commonwealth will effectively net off the costs of these services from the grants to the states, the states will not in the first instance receive a funding boost by the transfer of funding responsibility for outpatients and community health to the Commonwealth. However, the Commonwealth will be exposed to the growth pressures on these services.

In states where funding is based largely on historical block budgets, the transition to standardised national funding by episode will result in a significant reallocation of funding between hospitals. These states will need to finance transitional funding arrangements to smooth out the shift of funds from less efficient to more efficient providers. In these states there will also be associated political and industrial issues to address in implementation.

### **2. Transparent, activity-based funding for public hospitals, with responsibilities shared between the Commonwealth and the states, and the clear separation of funding for outpatient, sub acute and community health services has the potential to greatly strengthen public hospital systems.**

While Option A will present some challenges for the states, the proposed approach to funding public hospitals will promote:

- more national consistency moving in the direction of a national system as envisaged in Options B and C

- more certainty of funding which will support more confident planning of services and implementation of performance improvements at the hospital level
- improved morale for hospital staff as funding will be more closely related to meeting the demand pressures which they face
- possibly more autonomous management of public hospitals, at arm's length from governments, within clear funding and accountability parameters, moving in the direction of Regional Health Authorities as proposed in Option B.

A reinvigorated, confident public hospital system will be a necessary building block to achieve Option B or C, maintaining and enhancing this backbone of the Australian healthcare system.

**3. The strengthening of primary health care and the development of primary care organisational structures will create the community based service infrastructure necessary to:**

- support more coordinated and comprehensive primary care services
- better link hospital and community care, and
- for primary care to participate in the purchasing arrangements inherent in Options B and C.

The Commonwealth, in consultation with the states, will need to determine whether to promote new organisation structures for state community health services, possibly linked with other primary care providers (for example in Comprehensive Primary Care Centres) or to fund services where they are currently governed. The Commonwealth over time will need to develop more consistent arrangements for funding and for promoting a more comprehensive approach to planning these services while allowing for responsiveness to local needs. These arrangements will need to accommodate the full range of community health services, ranging from the Victorian model of autonomous community trusts to models where a community health service is organised as part of a hospital clinical team.

Private allied health services will continue as a major provider of community based care, funded by PHI and by patient out of pocket payments. There will be some scope for these services to be involved with Divisions of Primary Care or to be part of Comprehensive Primary Health Care Centres. If the Commonwealth moves to standardised funding for allied health services as part of community health there may be scope for private providers to be funded to provide some of these public community health services.

**4. Option A provides the basis for both Commonwealth and state jurisdictions to develop health service planning and purchasing capacity both in terms of purchasing systems and expertise.**

The recommended approaches to funding, based on various forms of episode and case payments and performance payments, will require the development of standardised national data, payment, billing, reporting and budgetary systems at both Commonwealth and state levels which will be necessary infrastructure for Options B and C. The new public hospital payment models will build on initiatives already undertaken at state levels and will necessarily build purchasing expertise at all levels of the health system.

**5. The introduction of a specific Commonwealth cost shared episode benefit of 40 % for public hospital inpatient care, based on a deemed efficient cost, and 100% for outpatient services could create pressures to increase the Commonwealth's role in the direction of Option B or C.**

Possible developments include:

- the Commonwealth progressively increasing its share of inpatient funding from 40% to 100%

- increased purchasing from private hospitals where the public hospital infrastructure is unable to meet demands eg for some specialties
  - increased merging of MBS and outpatient funding in public hospitals. This would need to have regard for impacts on staff specialists' rights of private practice.

## 2.2 Risks to Option A

The main risks in Option A are:

### **1. The States do not fully pass on the Commonwealth's episode funding model.**

To the extent that states choose to fund the inefficiencies in public hospitals, even on a transitional basis, the impact of the Commonwealth's 40% payment will be diluted. Some states may not be in a position to take on the political and industrial issues involved where there are large discrepancies between what a hospital receives as a block budget and a budget built up on an episode basis. There will also be questions as to how state systems fund overheads of area health services, shared services and other arrangements which weaken the transparency of individual hospital funding and performance. To overcome this risk the Commonwealth/state agreements may need to be prescriptive to some extent about state funding and organisational structures for public health.

### **2. Divided funding and policy responsibilities between Commonwealth and states create new dysfunctional service boundaries and new cost shifting incentives.**

This would require monitoring and would be a reason to move from Option A to Options B or C. As indicated above, it is also arguable that clearer demarcation of responsibilities could also support better linkages across jurisdictional boundaries.

### **3. Divided responsibilities between Commonwealth and states could be inflationary to health costs**

The division of funding and policy responsibilities could lead to duplication of services across jurisdictional boundaries. Again this would need to be monitored and would be grounds to move to one level of government responsibility under Option B or C. Option A will require effective intergovernmental dialogue and cooperation on the management of the system to avoid this risk.

### 3 Option B

The key elements in moving Option A to Option B are:

- National functions will continue in place, in particular:
  - the national performance reporting and accountability framework
  - the National Clinical Education and Training Agency.
- National Access Guarantees and Targets will continue to apply.
- Commonwealth sponsored primary care structures will have been established under Option A:
  - Comprehensive Primary Health Centres
  - Divisions of Primary Care
  - Evolved community health structures.
- The Commonwealth will take on responsibility for funding, policy and regulation of state public health services. The activity based funding system established for public hospital and related services established under Option A will be extended to 100% funding by the Commonwealth. The Commonwealth will already have developed its health services planning and funding skills under Option A.
- The Commonwealth will establish or recognise statutory Regional Health Authorities (RHAs) to plan and operate public health services for their populations.

RHAs could be based on networks of public hospital services which have become more autonomous from state health departments under the influence of the activity based funding models introduced under Option A. In smaller states the state health authority could become the RHA.

Under Option A, state public health services, which will form the basis of RHAs, will have developed some competencies and systems for responding to activity based budgets and purchasing for performance and outcomes. RHAs will need to further develop their purchasing and commissioning capability to fulfil their population based health responsibilities.

RHAs may be Commonwealth statutory entities to which the state owned public health assets would be transferred. RHAs could also be set up as state owned statutory entities under state legislation (similarly to public universities which are governed for policy and funding by the Commonwealth) This latter model would maintain some level of state involvement with health. A further alternative would be for RHAs to be set up as some form of community trust, similar to the arrangements for community health in Victoria or “foundation trusts” in the UK National Health Service.

- The Commonwealth will enter into 3 year funding agreements with RHAs which will be largely activity based budgets but with some flexibility of funding to address local needs by service innovation and some level of competitive purchasing where there are gaps in services.
- RHAs will form linkages with other service provider organisations in their regions including:
  - Divisions of Primary Care
  - Comprehensive Primary Care Centres

- Private hospitals
  - Not for Profit providers
  - Aged care providers
  - other private providers.
- RHA structures will provide opportunities for community engagement with the health services and their planning and priorities.
  - Specific service initiatives, such as Denticare, mental health and the National Indigenous Health Authority, introduced under Option A, will be well established, with RHAs taking responsibility for service planning and provision as may be required by these programs.
  - Universal national payment systems will be maintained for:
    - MBS
    - PBS
    - Aged Care

but there will be more flexibility for RHAs to undertake purchasing or commissioning in relation to the role of MBS in outpatient funding and for MBS equivalent funding for rural and remote areas. There should also be more scope for RHAs to negotiate arrangements with the Commonwealth to rationalise the funding of pharmaceuticals between the PBS and public hospitals.

- Private health insurance, private hospitals and private allied health services will continue in their current roles but there will be more scope for RHAs to purchase private services to meet service gaps for their populations in hospitals, subacute and community health services. There could also be scope for PHI to purchase from public sector services.

### 3.1 Leverage points of Option B

The major leverage points of Option B which could enable or drive further reforms in the direction of Option C are:

- 1. Under Option B provider structures for both public hospitals and primary health care will have been strengthened to the point where these entities are able to competently participate in a more competitive, performance based, purchasing environment, at arm's length from purchasers.**

Expertly organised provider organisations will enjoy greater autonomy and access to resources, based on performance, with commensurate improvement in morale, innovation and effectiveness.

- 2. RHAs could evolve to become either health plans or strong public health provider organisations under Option C.**

RHAs, as health plans, could encapsulate purchaser and provider roles as a form of HMO for a regional population. Alternatively, as provider organisations, public health services would continue to be the mainstay of the Australian health care system.

- 3. PHI and private hospitals will be under increasing pressure from their members and patients to offer more coordinated care across inpatient and community settings.**

As the community based services sector becomes better developed and more comprehensive, PHI will increasingly seek to support community based care, preventive services and case management for their members, although insurers will continue to be constrained by current premium structures. Denticare will also have provided PHI with experience in a social health insurance model.

Private hospitals will increasingly seek to link their patients to appropriate community based care and also are likely to seek to develop these service structures. Private hospitals and other private providers are also likely to increase their role in responding to contracting opportunities with RHAs to fill service gaps and shortfalls and to coordinate care.

These leverage points suggest that Option B can act as an enabler for Option C but it is much less clear what the trigger points could be which would create an imperative to move in the direction of C.

## 3.2 Risks to Option B

The main risk to the effectiveness of Option B, already identified by the Interim Report, is that RHAs could become subject to “provider capture” and fail to develop their population focused planning and commissioning/purchasing role. If this were to be the case, it would be a strong reason to move to Option C which separates purchasing and provision and supports an individual patient focus. Alternatively, the Commonwealth could be more prescriptive about the structures of RHAs and require a structural split between the purchaser/commissioning and provider roles of RHAs. For example, hospitals and community health could have their own autonomous governance within the RHA structure.

There would continue to be discontinuities between publicly and privately delivered services and there could continue to be inefficiencies across these interfaces. Community dissatisfaction with poor coordination of care and continuing difficulties in navigating the system could provide an impetus in the direction of Option 3.

## 4 Option C

The key elements in moving from Option B to Option C are:

- National functions will continue and be extended to provide the framework for the operation of health plans.
- National Access Guarantees and Targets will apply for health plans and at the hospital level.
- A strong, more integrated primary care sector will be in place with organisational structures which are able to respond to purchasing by health plans, especially in relation to management of patients with chronic and complex conditions. Routine visits to GPs will continue to be reimbursed on a fee for service basis either centrally by the Commonwealth under continuing MBS payment arrangements or payments operated by the health plans against an MBS type schedule. Enrolled primary care patients will be funded by other models of payment.
- The Commonwealth will cease to fund public health services directly and the activity and performance based payment frameworks developed by the Commonwealth will be taken up by health plans. The Commonwealth will set the payment framework to be used by health plans for the core elements of service delivery. This would be similar to the model in Germany where the national government sets the hospital fee schedule for the health funds based on AR-DRGs.
- RHAs will continue as strong public health organisations with autonomous governance but government would have step in rights in specified circumstances, similar to UK NHS foundation trusts or arrangements between state and local government in Australia. RHAs may continue to be state owned entities or could be Commonwealth statutory authorities or community trusts.

Under Option C the Commonwealth could withdraw from operational involvement with RHAs to become the regulator only. Alternatively, the Commonwealth could continue to be involved with RHAs through 3 year agreements which specify role delineations for the RHAs various facilities, agree major capital works investments and funding arrangements and in some cases the Commonwealth may subcontract with an RHA to undertake or participate in a national program, eg in health promotion. The latter arrangements would be desirable to ensure that RHAs maintain their strong public sector identity and mission.

The competitive pressures of Option C could encourage RHAs and primary health care organisations to merge and join forces within their regions to offer a comprehensive service range to health plan funders.

- Health plan organisations will evolve from a number of types of entity:
  - RHAs could become health plans for their regional populations. They would operate as a form of HMO in relation to their own services but would also purchase on behalf of members from other providers such as in primary health care or private hospitals or from other RHAs. Individuals would be free to enrol with their local RHA health plan or with any other health plan
  - large for profit and not for profit provider groups could seek to become health plans and would operate in a similar way to RHA health plans but could have national reach

- large private health insurers would combine mandatory social health insurance and optional private health insurance offerings as occurs in a number of European social health insurance systems
- new entities could enter the market place.
- RHA structures would continue to offer the opportunity for community engagement on a regional basis, while health plans will become individual patient advocates seeking to fund the most appropriate range of services for patients who need to navigate the system and access a range of connected services. Health plans will also have the potential for a population health focus with their members and may offer prevention and early intervention programs.
- Specific service initiatives such as Denticare and mental health would be subsumed by the new arrangements. The National Indigenous Health Authority and DVA would continue as separate funders and purchasers. Commonwealth aged care programs would also continue. Rolling in of aged care to health plans could be considered as a later iteration once Option C is well established.
- Universal national payment systems of MBS and PBS could be maintained either as Commonwealth operated programs or their operation could be devolved to health plans as a core funding guarantee for all Australian citizens. In the USA, for example, health insurers administer the Federal Medicare Program in respect of their members. Health plans would have some flexibility to offer equivalent funding or case funding rather than episodic fee for service for some categories of patients and in some geographies.
- To maintain the current level of private financing of health care and not increase the burden of taxation under Option C, private hospitals would need to continue to be primarily funded by private health insurance. Specific policy settings would be required to maintain private health insurance at the present level of 45% of the population, including consideration of appropriate premium subsidies.

An alternative scenario would be for health plans to purchase the core offering of free hospital cover from both public and private hospitals and for both public and private hospitals to offer extra service levels which would be funded by private health insurance. Whether this would be sufficient to continue to attract citizens to take out PHI and whether the private contribution for extras would maintain the current level of private financing which applies for private hospitals would need to be tested by econometric and actuarial modelling.

- The health levy could be introduced iteratively with the various categories of publicly funded services being incorporated in health plans over time. The limitation of this approach is that health plans would not be able to purchase across the care continuum until all publicly funded services were covered by plans.

## 4.1 Key Leverage points of Option C

The key leverage points which deliver benefit in Option C are:

- 1. An element of competitive purchasing is introduced amongst health plans to offer the best value to members and amongst providers to offer the mandatory set of services.**

The benefit of this competitive model is that it offers the consumer choice and a level of control and entitlement in accessing needed health services. Also providers are encouraged to innovate and, because health plans fund services across jurisdictions, there is a stimulus for providers to collaborate to deliver end to end care which will be appropriately remunerated.

As the Interim Report observes, the model also allows public facilities to operate more like private entities which are paid for the work they do (in preference to capped budgets) with resulting benefits in the way health facilities are managed, including improved staff morale, opportunity for reward for performance and financial sustainability.

The model also allows for greater harnessing of private providers and private investment to meet health care needs of the community.

- 2. A mandatory service entitlement is defined which supports end to end patient care and which is fully funded through health plans.**

Option C arguably offers the most comprehensive approach to integrating health services around patient needs while maintaining the diversity of provider arrangements in both the public and private sectors and reducing duplication, discontinuities and gaps across jurisdictions. If health plans are responsible for all health funding then they are strongly incentivised to keep people as well as possible by mobilising the most appropriate range of services.

## 4.2 Risks to Option C

- 1. The Interim Report identifies the primary risks of Option C as increased transaction and marketing costs, as well as Option C representing the most significant departure from current arrangements of all three options. Once Option A is in place, however, it is arguable whether a system of quasi autonomous RHAs or a system of competing health plans would be the more radical option.**

In relation to transaction costs, the introduction of activity based payment systems, pay for performance measures and various purchasing models implicit in both Options A and B would already increase transaction costs and increase financing complexity for providers. Private hospitals already operate under a multiplicity of PHI contracts each with a different payment model. In the less expensive UK system, hospital trusts operate with a range of contracts from various primary care trusts. Under Option C there would be more consistency of health plan payment models based on the national standardisation of hospital payments under Options A and B.

Increased transaction costs would need to be weighed against efficiency savings resulting from health plans being in a better position than other options to purchase the right care at the right time at the right place across the care continuum and across jurisdictions.

The higher costs of the European social health insurance systems could also be attributable to the uncapped nature of their hospital cover and the requirement on health funds to cover a more comprehensive range of care. The introduction of activity based funding for public health services in Options A and B will already have had an inflationary impact on the volumes of

hospital services. Option C offers potentially greater scope to purchase alternative services and to implement effective demand management.

Again, econometric and actuarial modelling could be used to quantify the relative costs and benefits of the 3 options.

**2. Another area of risk of Option 3 relates to the role of the public health system and how a strong public health sector can be maintained in a competitive purchasing environment in which other private providers will no doubt seek to compete.**

This is currently a challenge for public universities where, under Commonwealth legislation, private entities can be recognised as university level institutions, with their students eligible for fee help programs and in some cases HECS places being made available. In the case of the public universities, the response has been to compete back and there are many examples of innovation and student focussed initiatives resulting from this competitive environment. In the outline of Option 3 above there are some suggestions about how RHAs can be structured to maintain their public sector identity.

**3. A third area of risk relates to how to maintain the public private mix in financing health care so that more and more does not fall upon the tax based health levy.**

This has been discussed above in relation to the place of private hospitals under Option C. It will also be necessary to define carefully the mandatory set of services to be covered, which services are to be free at point of delivery, which will attract a copayment and on what basis, and which services will be covered by PHI. If health plans are to be completely agnostic as to which services, public or private, they purchase from using the health levy, then careful consideration will need to be given to how to maintain the value proposition for PHI, if the current public-private mix in funding is to be maintained.

## 5 Conclusion

The views expressed in this paper are personal to the author and are intended to provide a framework for the Commission's discussions and deliberations at its meeting on 18 October 2009.

The three options are not mutually exclusive. There are elements in all three which could form part of the Commission's final preferred governance model. For example, it is arguable that public hospitals would benefit from:

- the transparent, accountable activity based funding with clear funding rules from government in Option A,
- the networked, population focus of RHAs in Option B, and
- the greater autonomy, flexibility and scope for innovation of the competitive purchasing approach in Option C.

The benefits of the three Options could be characterised thematically as:

- Option A: a rebalanced primary and acute care system with clear demarcations of responsibility
- Option B: a population health focus with single funding accountability
- Option C: an individual consumer focus, offering choice with end to end security of care.

The challenge for Commissioners will be to determine how these benefits can be maximised in a workable, achievable governance arrangement that can be readily leveraged from the current governance structures and competencies.

## Appendix A Appendix: Achievement of Key Characteristics of Future Health System

The above discussion seeks to analyse the three options having regard for the Commission's identified key characteristics for a future health system. A schematic way of assessing the options against the key characteristics is presented below. The scoring system is subjective but provides a framework which the Commission may wish to apply to guide its deliberations. It is assumed that each option builds on the previous one and therefore the benefits in most instances tend to be cumulative.

### Key Characteristics of Our Future Health System

Characteristic	Option A	Option B	Option C
Centred on people and families	+primary care initiatives +subacute initiatives	+ + +regional integration and population focus of RHAs	+ + + +health plans purchase across the care continuum
A wellness system	+primary care initiatives +subacute initiatives	+ + +population focus of RHAs	+ + + +health plans have an interest in supporting prevention and early intervention
Reshaping and rebalancing the continuum	+primary care initiatives +sub acute initiatives +hospitals better managed under activity based payments and performance systems +more choices in aged care	+ + ++hospitals managed more autonomously and coherently + +regional integration and population focus of RHAs	+ + ++ + + +health plans purchase across the care continuum
Robust investment: toward higher productivity, quality, outcomes	+bundled and performance payments in primary care +activity and performance based payments for hospitals	+ + +RHAs are in a better position than Option A to link to primary care etc to improve patient outcomes	+ + + +competitive purchasing promotes productivity +health plans purchase across the continuum to improve outcomes
Fairness of access	+Universal access to defined programs +cost shifting of patients reduced	+ + +improved referral of patients between RHAs and primary care	+ + + +health levy and health plans purchasing on behalf of members will increase individuals access to entitlements
Engage and empower people, carers, patients, health professionals	+activity based payments will empower staff and patients in hospitals +primary care initiatives will enhance user and health	+ + + +RHAs provide greater	+ + + +

<b>Characteristic</b>	<b>Option A</b>	<b>Option B</b>	<b>Option C</b>
	professional satisfaction +cost shifting reduced	autonomy and work place satisfaction for public providers	+health plans empower patients-all patients are private
A culture of continuous improvement, innovation, perpetual reform	+primary care initiatives will drive reform +activity based payments for hospitals will drive reform	+ Some risk that RHAs structure could become rigid and offer less flexibility	+ +competitive purchasing will be a stimulus for innovation and reform