

**Options for reform of
Commonwealth and State
governance responsibilities for the
Australian health system**

**A paper commissioned by the
National Health and Hospitals Reform Commission**

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Table of Contents

The task	1
Some important terms defined	1
Our approach.....	3
What problems are we solving?	4
Problems for patients	4
Problems of system design	5
What would better governance and system design mean for patients?	6
How can we get there from here?	8
A longer term view	9
Six Design Principles.....	10
Options for the governance and financing of Australia's future health care system	12
Option 1: Commonwealth takes responsibility	13
Option 2: States take responsibility.....	16
Option 3: Joint Commonwealth: State Health Commissions	19
Option 4: Renovate	21
Common features	23
Scope.....	25
Private and non-government sectors.....	25
Conclusions: Can we get there from here?	27
References	28
Attachment 1: Technical Issues.....	29
1. Purchasing	29
2. Funding for accountability.....	29
3. Integration of organisational structures	30
4. Breadth of health authority roles.....	30
5. The role of Boards	30
Attachment 2: Improving equity of access to MBS and PBS	32
Attachment 3: What the options mean for primary health care	34

List of tables

Table 1: Current location of main governance functions	4
Table 2: Some patient care problems that could be resolved under new arrangements.....	6
Table 3: NHHRC proposals for single accountability, April 2008	8
Table 4: Governance functions in the Commonwealth option.....	13
Table 5: Governance functions in the State option	17
Table 6: Governance functions in the Joint Health Commission option.....	19
Table 7: Governance functions in the renovation option	23
Table 8: Per capita MBS and PBS funding by state and territory 2007/2008	32
Table 9: Investment required to achieve equity (unadjusted for need) between the states in MBS and PBS funding (2007/08 dollars).....	33
Table 10: Reform priorities for primary health care	34

Options for reform of Commonwealth and State governance responsibilities for the Australian health system

The purpose of this paper is to provide advice on options for governance reform of Commonwealth-state responsibilities for the Australian health system, for consideration by the NHHRC. The service design and governance principles published by the Commission in *Beyond the Blame Game*, along with the concept of single accountability, have been used as a framework for our thinking.

The task

We were asked to address two main questions:

- What are the options for change in governance structures and processes that would enable single accountability for major elements of the health system? The options should be shaped with regard to the Commission's service design and governance principles, and with the allocations of accountability proposed in the Commission's first paper, but not limited to them.
- How might the performance of the five major governance or stewardship functions – funding, ownership, purchasing, provision and regulation – be strengthened as the system moves towards single accountability?

The task is to address the governance of the **health system** as a whole (and as defined above, also major structural design elements including arrangements for purchasing and provision of health care). Good governance is required at all levels (specific types of health services, facilities, regions and so on) but this paper addresses other levels only in relation to system governance.

In addressing questions about system governance, we were also asked to consider the set of more technical issues included as Attachment 1.

Some important terms defined

Governance for present purposes is defined as the structures and processes by which the health system is regulated, directed and controlled. It includes the obligations of stewardship – ensuring that the system is well sustained for the future as well as serving the needs of the present. Governance is done by the people in charge – their authority is matched with accountability. Governance in a large complex system happens at several levels.

The importance and limits of health system governance

Good governance of the health system is necessary. But it alone will not solve the major problems confronting the health system. Effective governance removes barriers, gives permissions, sets directions, better allocates resources and enables change. It does not solve patient care problems, but it can create the conditions under which problems become solvable.

As noted above, this paper focuses on governance at system level, with less attention to governance at health care delivery level, and it does not address governance *within* the

private sector. However, we do briefly address the role of the private sector in relation to the major system-level functions, and in particular purchasing and provision of health care.

Health system is used to include health and aged care (because these are the two major sectors of the system in and between which split responsibility causes great problems – see below). There are other more difficult questions of scope (how much disability care should be included? What about other human services?) that we address towards the end of this paper.

Purchasing and commissioning are terms that refer to active decision-making by funders about what health care should be ‘purchased’ on behalf of consumers, how and from whom (Harding and Preker 2000). This method has developed as an alternative to simply paying providers for what they traditionally do (hospital care, mental health care etc). A purchasing approach requires clear separation of the roles of funding and providing health care, and can be applied regardless of the mix of public and private ownership and funding within a health system. The World Health Organisation has argued that strategic purchasing should be considered as a major option for improving the performance of health systems, because it can support resource shifts across care boundaries to achieve effective interventions, as well as reducing ‘administrative rigidities generated by hierarchically structured command-and-control models’ in publicly operating systems. Purchasing can also create incentives for provider responsiveness and efficiency, and promote decentralisation of health service management (Figueres et al, 2005:4). While there are some circumstances where purchasing is undertaken on a competitive basis, this is not often the best approach in health care. The term ‘commissioning’ is used in this paper to distinguish it from commercial purchasing in the market place. Purchasing/commissioning decisions are translated into contracts with health care providers, not into commercial sales.

Corporatisation is defined as the restructuring of public health services into public sector or not for profit non-government corporations. Management decision making is decentralised to the hospital/health service Board of Directors. Internationally, corporatisation reforms have been undertaken in countries such as Canada, the UK and New Zealand in an attempt to ‘mimic the structure and efficiency of private corporations while assuring that social objectives are still emphasized through public ownership’ (Harding 2000:15).

Single accountability in this paper means that one level of government is held to account for the performance of particular parts of the health system, or the whole health system (within the boundaries of government roles). Single accountability can be achieved by structural reform so that only one level of government has a role; or it can be achieved through financial and other incentives and penalties that give government incentives to ensure performance. For example, the Commonwealth and the states could agree that the Commonwealth would pay the states directly for every public hospital day of stay by someone who would not be in hospital if (Commonwealth-funded) residential or step-down or home-based care were available. The Commonwealth would therefore have a strong incentive to ensure access to the right kind of care when needed (because acute care is more expensive).

Our approach

In a vigorous public debate about the future of the health care system, there have been many different prescriptions for change in structures and governance – Commonwealth take over, local boards, funds pooling, managed care, population health funding, Medicare Gold, privatisation of health care delivery, and so on. It seems that everyone agrees change is needed, but there is no consensus on the direction of change. Or if there is – for example, everyone seems to agree that the split of responsibilities between the Commonwealth and the states¹ is dysfunctional – agreement breaks down at that point.

The prescriptions seem to go nowhere. So far, there has been a sense that the vested interests of so many different stakeholders have created policy gridlock – every possible direction of change is blocked by the interests of one important group or another (including the interests of government health authorities themselves). There also seems to be disagreement or confusion about the role of governance structures and processes – what governance arrangements can and can't do.

In this context, we have concluded that the most useful approach we can take is to start by defining the problems the system needs to address, and articulating the design features that are desirable to enable those problems to be solved or ameliorated. In this way, we seek to make clear the logical links between goals and options. Accordingly in what follows we make explicit the logic of our analysis, and the layering of governance structures and processes, in a way that is designed to identify the pathways governments and the health system could take. In keeping with the Commission's terms of reference, we have focused on the role of governments as the major decision-makers for the health system, while not ignoring the private sector.

This short paper is necessarily schematic in its analysis of design options. Its purpose is to clarify the choices that can be made. Once a choice is made, much more detailed work will be required to translate the preferred option into a national implementation plan.

There are many important areas of care that are not specifically addressed. For example, we have not said anything about the current problems with dental care, or those facing younger people with disabilities who need residential care. Neither have we properly addressed the activities known (somewhat confusingly) as public health – primary prevention of illness and injury, healthy public policy and related roles. They are currently shared among all of the main players, for good reasons – policy and action are required at national, state, regional and local level on different aspects. This critical function falls both within and outside of the health system.

We begin with a consideration of the major problems we are seeking to address and the related design principles. We then outline a decision pathway by which options can be constructed and ultimately chosen. Four possible options are outlined, along with some common features that we suggest could be part of all options. We conclude with some suggestions about required next steps.

¹ We use 'state' to mean both state and territory jurisdictions.

What problems are we solving?

Table 1 below summarises some major current roles in relation to the five governance functions. This is not meant to be comprehensive (and excludes, for example, the roles of professional boards and learned colleges) but is simply designed to illustrate the complexity in current governance arrangements.

Table 1: Current location of main governance functions

Function	Commonwealth	States/Territories	Private/NGO sector
Ownership		Public hospitals, community & public health	Private hospitals and Aged Care Facilities, private practices
Funding	Residential and some community aged care, MBS, PBS, DVA, State grants, Indigenous PHC, 30% rebate on insurance	Public hospitals, community & public health, ambulance, some public dental services, accident compensation and disability care	Health insurance, accident insurance
Commissioning	Limited - DVA and some NGO community care	Varies - some hospital and NGO services	Limited - some insurers
Provision	Australian Hearing, C'wealth Rehab Service, Health Services Aust.	Public hospitals, community & public health, ambulance	Private hospitals and RACFs, private practices
Regulation	Residential aged care, food standards, health insurance	Public and private hospitals, community & public health, workforce	

Even with this complexity, there is much in the Australian health system that works well, including in its governance. However, based on our analysis of current debates and our own observation of dysfunctional arrangements in the health system, we suggest that there are nine main problems that any system-level changes should address. They are at two levels – the problems that directly affect access to effective care for patients; and the problems that directly affect the performance of the system.

Problems for patients

1. There is inequitable access to services, shaped by place (especially remote and rural location) and financial barriers to care, among other factors. This is particularly the case for those services funded under fee for service arrangements. While the health care you receive should be based on your need, where you live and how much money you have too often determines what you actually receive and how quickly you receive it.

2. Services are fragmented for those who require ongoing care for complex and chronic conditions. While the current arrangements work reasonably well for those of us who have only occasional or episodic health problems, they are not well designed to respond to the needs that some of us have for coordinated, ongoing care.

3. The primary health care sector is fragmented and not well developed.

This problem most affects those who need ongoing care for chronic conditions, and those in remote and rural areas. But it also applies more generally – for example, depending on where you live, you may or may not receive automatic access to support and advice as a new mother. Finally, there is too little effort in prevention of illness and injury, a potentially important function of the primary health care system.

Leutz's Laws of Service Integration

Based on a comparative UK:USA study, Leutz developed 6 principles to guide integration of health and community care:

1. You can integrate some of the services for all the people, and all the services for some of the people, but you can't integrate all of the services for all of the people.
2. Integration costs before it pays.
3. Your integration is my fragmentation.
4. You can't integrate a square peg and a round hole.
5. The one who integrates calls the tune.
6. All integration is local.

Source: Leutz (1999, 2005).

Problems of system design

4. There is a bewildering array of funding programs, each with its own eligibility criteria, accountability requirements, timelines and access barriers. Even experienced managers and clinicians find it hard to be sure their services are getting the funding they're eligible for. Duplication and gaps are the norm. Funding complexity spawns regulatory and reporting complexity – witness the complicated requirements for GPs, and the overhead costs of administering 'vertical' population health programs.

5. Blame- and cost - shifting between levels of government is a major barrier to improvement in the system of care. This problem has been addressed in the Commission's first paper. The current split of responsibilities sets up perverse financial incentives for governments, whereby one level can 'win' financially through measures that cause the other level to 'lose' financially. The impact on patients and care providers is significant, in the form of unnecessarily fragmented and complex referral and care pathways. But cost shifting is also highly inefficient – witness the number of state funded hospital beds that are occupied every day by patients who cannot access Commonwealth funded residential or transition care when they need it. The resultant blame-shifting (the policies and structures that enable finger-pointing and work against problem-solving) creates an additional barrier to performance improvement.

6. The workforce is pressured, jobs are less satisfying, we face serious supply problems and skills are not best utilised. While we have shortages now, the current workforce is ageing, and future shortages are predicted to be severe. The jobs offered to skilled staff tend to be defined in ways that were perhaps appropriate 30 years ago but are not optimal for current and future health care models.

7. The relationship between government, non-government and private services is suboptimal and contentious. Reflecting the bewildering array of funding programs, there is a bewildering array of public, private and non-government health care providers, delivering only some of what a consumer requires and lacking effective linkages to other agencies and

care options. Relationships between health agencies are too often dependent on personal relationships rather than transparent communication and referral systems. Coordinated planning of the government, non-government and private sectors is the exception rather than the norm.

8. Decision-making is too removed from front line service delivery. In the public sector in recent years, operational decision-making has become more centralised, with many layers between those at the front line and those who hold decision-making authority. At the moment, all state health authorities (with the partial exception of Victoria) have centralised governance to state level. Many are operating at a larger size with less delegation of operational decision-making than would be seen to be feasible in the private sector or in other public systems. Further, there are inherent conflicts of interest with health departments being expected to exercise their Westminster responsibilities of serving the government of the day while at the same time carrying operational responsibility for health service delivery.

9. It is too difficult to introduce and sustain new models of care and other innovation. While the policy debate goes on, and all the problems listed above take their toll, providers and policy workers in all sectors continue to experiment, redesign and seek to improve services. But change is very hard to make, and even harder to sustain. The jungle of funding rules, split responsibilities, laser-like targeting of eligibility criteria and professional role demarcations generally seem to overgrow a new model of care once the project funding and energy are exhausted. Change is too often lost and too seldom replicated. Similarly, the money and effort expended to get IT systems that can deliver needed information at the right place and the right time seems out of all proportion with the modest results.

What would better governance and system design mean for patients?

Structures and policies at system level can seem very remote from the problems that patients and care providers in all sectors would like to see resolved. To illustrate the ways in which changes in governance *could* affect access and the quality of care as well as the roles of health care providers, we outline some typical patient care problems, and then explain what *could* be different if the split in the responsibilities of government were resolved and equitable funding were available. We introduce here some arrangements that are explained later in this paper.

Table 2: Some patient care problems that could be resolved under new arrangements

Patient Care Problem	Potential improvement
<p>Patient in a remote area: Your small community doesn't have a GP. The Commonwealth Department of Health and Ageing cannot assist.</p>	<p>An alternative method of providing access to GP care is organised by your health funding authority (which allocates public health funding for your region), by contracting with a medical organisation that employs GPs for this purpose. [This is already happening in some remote areas through special arrangements]. This arrangement can't alone solve the shortage of GPs, but it can influence redistribution. Alternatively, a different set of financial incentives for the Commonwealth could mean that the Commonwealth is more actively engaged in setting incentives for GPs to work in small remote communities where fee-for-service is an inadequate method of payment.</p>

Patient Care Problem	Potential improvement
<p>General Practitioner: Your elderly patient who til now has been coping at home attends on a Friday afternoon clearly too frail and confused to be safe over the weekend at home alone. In desperation, you send him to the local hospital emergency department, knowing they'll have to keep him safe at least til Monday.</p>	<p>Your practice nurse is now able to seek emergency access to transition care in a nearby aged care facility for your patient, where he will be cared for over the weekend, and assessed as to his need for home-based support or accommodation in residential care. Home-based support services are organised a week later, and your patient is discharged home on the following Monday, with both formal carers and family support organised. You are involved in formulating his care plan, including adjustments to his medications, and you are notified at least 24 hours in advance of his transfer home. You have access to the clinical pharmacist from the transition care facility to help you to monitor what are likely to be ongoing changes in medication needs. This happy outcome is made possible because the regional funding authority has decided to invest in transition care for precisely this sort of situation, and can afford it because there are enough avoided hospital admissions to make a difference.</p>
<p>Diabetes educator: Your community health-based diabetes education program should be available to all newly diagnosed patients in your catchment area, but you are the only staff member who can do this work and you can only get to 40% of those who need your program.</p>	<p>Your local primary care network (involving community health, general practice, representatives of local private allied health and diagnostic practices, medical and nursing specialists from the local hospital, two community representatives and a planner from the regional funding authority) identifies better management of diabetic patients as one of three main priorities in this year's plan. The planner undertakes to conduct an analysis of the benefits and costs of making diabetes education available to all, and a working group prepares a care proposal to guide this work. If the analysis shows a net benefit, the RFA will seriously seek to respond, because even though there will be an upfront additional cost, the savings over time from better diabetes management will accrue to the RFA's commissioning budget.</p>
<p>Patient with a serious chronic condition requiring coordinated care: Even though you have a GP who does her best, you can't get the services you need when you need them, because of barriers between private and public, Commonwealth- and state- funded services, and rationing of some services.</p>	<p>You are assessed and enrolled in a special program for people with chronic conditions, and your GP arranges for a care coordinator (in the private or public sector) to be contracted to organise your care, drawing on all the resources available. You pay less for medicines, your GP has better access to your various specialists for advice and coordination and the care coordinator arranges payment for all the allied health and home care services you require, whether in the private or public sector. Your care coordinator works with your GP and medical specialists to plan for your continuing care needs and ensure that everything that helps people with your condition to stay as well as possible for as long as possible is available. This includes making sure that you (and your family or carers) have the information and support you need to take good care of yourself and to have a good quality of life.</p>

How can we get there from here?

We have taken the nine problems outlined above as the challenge that any options for change in governance structures and functions should address. Good governance can't alone solve most of them. For example, good governance won't of itself solve workforce problems, but it might make jobs for health professionals more satisfying, and enhance their ability to improve care. Good governance is a necessary but not sufficient condition for improvement - it can remove barriers, give permissions, set directions, better allocate resources and enable change.

The Commission in its first paper focused on accountability by governments to the community and suggested an allocation of accountability for parts of the health system that largely matches the current funding responsibilities. The allocations proposed are shown in Table 2.

The Commission's proposal that the nominated level of government accept accountability for the relevant sectors without the matching authority is an expedient but we think unsustainable arrangement, requiring the development and maintenance of sophisticated monitoring and financial incentive systems. As the Commission acknowledged, the other problem is that it is technically difficult to separate some of the identified sectors. For example, how can responsibility for maternal and child health not be part of primary care? And how can mental health be separated from community health? While the Commission's proposals would no doubt solve some problems, others would inevitably be created and new blame- and cost-shifting possibilities would be opened up. This is consistent with Leutz's third law – 'Your integration is my fragmentation' (Leutz 1999:91).

Table 3: NHRC proposals for single accountability, April 2008

Sector of health system	Level of government suggested by the Commission in its 1 st report
Primary health care (including GPs and community health)	Commonwealth
Public hospitals	State
Mental health	State
Maternal and child health	State
Public health	State
Aged care	Commonwealth
Illness prevention	Commonwealth

On the other hand, major structural change is always painful and expensive, and usually requires several years of transition and re-development before benefits are realised. However, there is an opportunity now to focus on a long term vision for the health system of the future, that could enable Australia to meet the challenges the health system faces over the next twenty years and more. We note that Australia is not alone in this. All OECD countries are grappling with the challenge of ageing populations and increasing burden of chronic disease for which current health funding and delivery structures are not well suited. A key question in the Australian context is whether the translation of such a vision into reality

will be possible without more fundamental structural reform of our health and aged care systems.

A longer term view

While the Commission's proposals in its first report will help in the shorter-term, more fundamental reform will be required for the future. The nature and scope of this reform should be shaped by the response to three fundamental questions. The first logical question is this:

Three fundamental questions

1. If we maintain the split of responsibility between the Commonwealth and the States/Territories will it be possible to address the big problems that will face the Australian health care system of the future?
2. Is it possible to address the problems of split responsibility without structural change in accountability (ie the allocation of authority over funding, regulation, performance)?
3. Who should be held accountable for health system performance, and by extension, who should be responsible for funding health and aged care delivery?

1. Can the nine problems listed above be addressed without ending blame-shifting, or to put it in governance terms, without resolving split responsibility?

We suggest that the answer to this question is no, and we support this conclusion with the evidence of both Commonwealth and state-based attempts at reform in recent years. As previously reported (see, for example, Rix et al 2005 and Dwyer 2004) recent reviews and restructures in every Australian state can be read as attempts to address these very problems in the absence of a solution to split responsibility. While many good ideas have been formulated, and much good innovation work has been done, the fundamental problems remain.

Our conclusion is that any attempt at long-term serious reform of the Australian health system must tackle the fundamental problems that arise from the split of responsibility between state and federal governments, including the resultant split between policy and funding for 'health' and 'aged care'.

The second big question then is this:

2. Can the problems of split responsibility be addressed without structural change in accountability (ie the allocation of authority over funding, regulation and performance)?

We suggest that the answer to this question is probably not or, at least, not for long. But there are some significant improvements that could be made in what we call the 'renovation option', which we outline later in this paper.

If we then pursue the options for bringing government health care accountability under one umbrella, the next logical question is:

3. Who should be held accountable for the performance of the Australian health system, and with it, be responsible for system-level governance and funding of health and aged care delivery?

While all entities within the health and aged care systems need to take responsibility and be accountable for their performance, at government level there are three logical options, the

Commonwealth, the states, or separate bodies which we call Joint Health Commission/s (JHC's).²

We have developed each of these options in this paper. In doing so, we first applied some design principles.

Six Design Principles

The six design principles we have adopted are:

1. Only fix what's broken

Change is expensive (though hopefully less so than no change) and disruptive. Changes should be considered by exception, or on the margin. That is, we assume that everything not explicitly changed in the options outlined below continues as it is, at least until those responsible under new arrangements make alternative decisions. This principle is necessary when the project is to change a large complex system while it continues to operate 24/7/365. It includes a starting position that the benefits of existing efficient arrangements (such as Medicare Australia's role in processing payments to providers of care) should be retained.

2. Enact national leadership

The community's strong expectation of national leadership and some consistency across the country should be honoured through a capacity for national policy making, continuation of some existing national arrangements (and the creation of some new ones), and through the establishment of a national health charter (or statement of health care entitlement - see the section on common features later in this paper) which would underpin 'people and family centred care' (NHHRC, 2008, p 36).

3. The system must be designed as a system, with coherent roles, authorities and accountabilities

The design of national health systems is not a problem with a single right answer. There are many combinations of governance and other design elements that can work in different cultures, geographies and populations. The challenge for Australia at this time is to find a coherent set of arrangements that will work for us, building on the strengths of what we have now, our established preferences (including the principles of universal access and choice), and an awareness of the future challenges the system will face.

4. Maintain the universality of Medicare

A key strength of the Australian health care system is Medicare and the entitlement that all Australians have to the medical and pharmaceutical benefits it provides. In accordance with the Commission's terms of reference, Australia's national Medicare system needs to be maintained and potentially strengthened.

5. All service integration is local

While it is clear that people with complex and chronic conditions need better coordination than is supported by current system arrangements, it is also true that service integration is neither necessary nor economic for other kinds of needs, and won't be comprehensive. We therefore

² The concept of Joint Health Commissions is largely based on the work of John Menadue. See, for example, <http://cpd.org.au/article/health-coalition-of-the-willing>

accept Leutz's sixth law of service integration, which is that integration has to be implemented locally to suit local needs and conditions (Leutz, 2005:9). The corollary is that larger policies should facilitate rather than dictate the shape and speed of change of local arrangements. A further corollary is that coordinated regional health planning is essential.

6. Accountability for funding and commissioning health and aged care is just as important as accountability for providing health and aged care

The functions of commissioning and providing health care should be clearly delineated, in order to enable accountability for both commissioning decisions and good care delivery.

The 'purchaser-provider split' has a chequered history in health care. Experiments in complete separation of these roles, notably in New Zealand in the 1990s, have not achieved the stated goals (Ashton et al, 2005). It can also be difficult for purchasers or commissioners to get the incentives right because small movements in definition or price can have large effects on delivery. Further, providers hold many of the skills, have a wide knowledge base and have the local background knowledge needed for wise commissioning decisions.

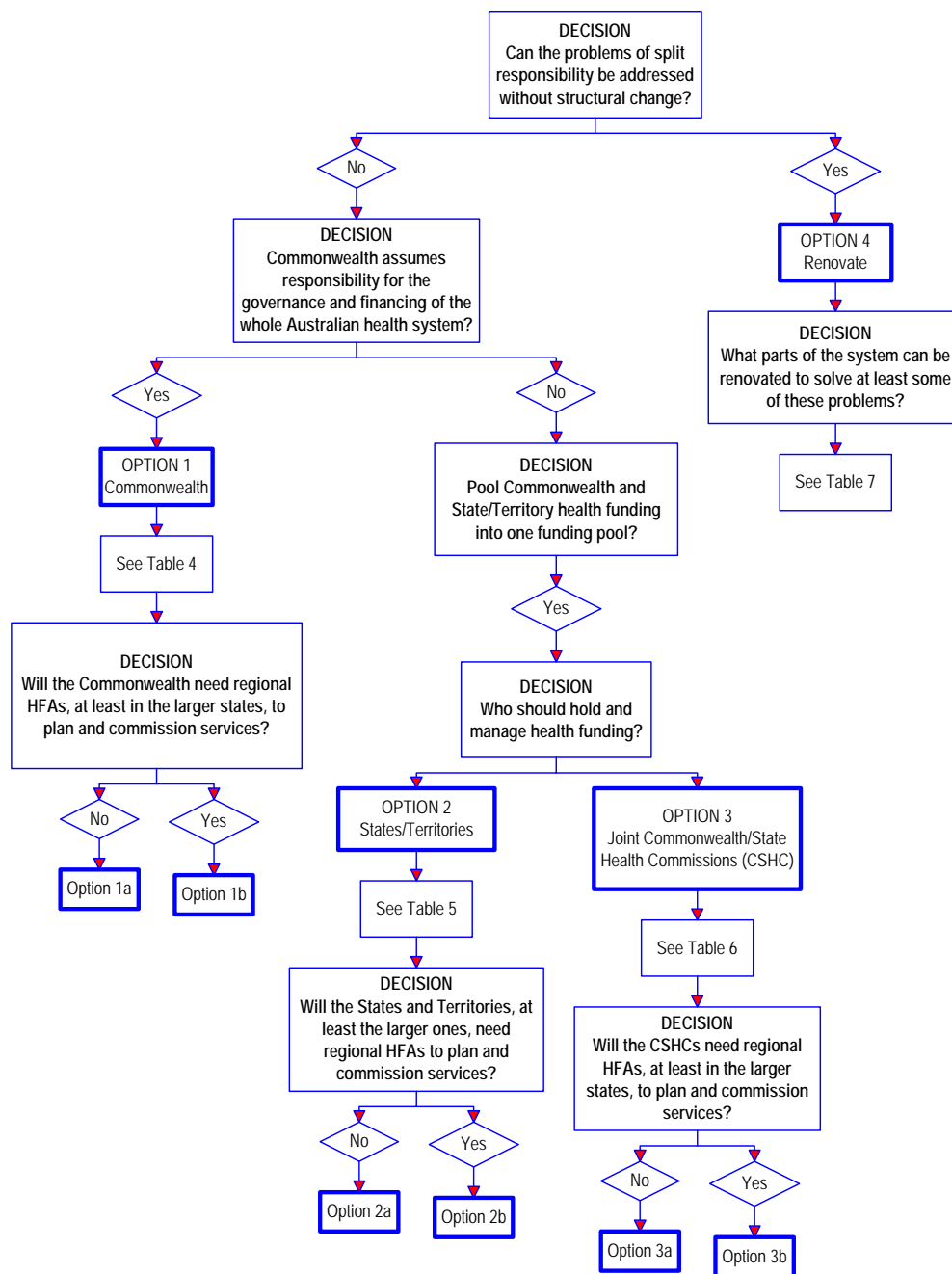
However, active commissioning has proven important in some aspects of reform of care delivery, for example in mental health care, where government health authorities have acted as commissioners, defining models of care and awarding contracts to a new range of providers. Conversely, some role separation enables providers to focus more closely on leading and directing the operations they are responsible for.

We suggest that commissioning may be more important when health care delivery is being reformed; and that while the system may benefit from a range of approaches to commissioning for different purposes, attention to the commissioning function is critical in system design.

Options for the governance and financing of Australia's future health care system

The options described in this section flow logically from different answers to the reform questions we posed above. While there are more complex options to be considered in detailed system design, and some common features, the schematic decision pathway shown in Figure 1 identifies the high level choices that define the options that follow.

Figure 1 Decision pathway



Option 1: Commonwealth takes responsibility

In this option, the Commonwealth takes responsibility for the governance of the entire health and aged care system and its public funding, and with it, clear accountability to the Australian people for overall performance of the health system. Fiscal arrangements between the Commonwealth and the States and Territories are re-balanced, so that all funding for public health and aged care functions is retained/recouped by the Commonwealth.

The Commonwealth is the sole funder of the public system. This means that it alone is accountable to the public for the amount of public funding spent on health care and for how that money is spent. Its role in relation to the private system (such as private services funded by MBS or PBS and Private Health Insurance) remains as is. In addition to its traditional role, the Commonwealth is responsible for commissioning public health services. The combination of responsibility for funding and/or regulating both public and private delivery will provide opportunities for the Commonwealth to develop programs that better coordinate or integrate patient care across these sectors.

Providers continue with current ownership arrangements – state, NGO, local government or private sector. The Commonwealth is free to commission health and aged care from any sector.

Table 4: Governance functions in the Commonwealth option

Functions	Commonwealth	States	Private/NGO
Funding	Yes. Maintenance of the current functions of Medicare Australia – plus contract services from a range of providers	No	As is
Ownership	No – as is	As is or corporatise	As is
Commissioning	Yes	No	As is
Provision	As is	As is or vacate	As is or contracted
Regulation	Most	Residual statutory responsibilities, reduce over time	Contracted out as expedient
Other issues	While the Commonwealth has considerable expertise in managing fee for service reimbursement schemes, it has little experience in funding or managing other health care. Nor does it have expertise in equity-based population planning. The new role of the Commonwealth is not compatible with current DoHA culture or expertise. Significant change would be required within DoHA, particularly if it were to retain commissioning functions internally (see below).		

There are two sub-options under the Commonwealth model.

Option 1(a) – the Commonwealth plans and commissions all health and aged care services

Under this option, the policy, planning and monitoring functions of the states transfer to the Commonwealth and these functions are undertaken by the Commonwealth Department of Health and Ageing (DoHA) through its Canberra and regional (capital city) offices.

Option 1(b) - the Commonwealth establishes regional Health Funding Authorities (HFAs)

Under Option 1(b) the Commonwealth establishes HFAs to undertake the commissioning function, on the basis that it could not sensibly be done from Canberra or through the capital city offices as currently structured. Regions might be whole states (in Tasmania, Northern Territory, ACT and perhaps South Australia), or might cross state boundaries (eg a commissioning authority for Northern Australia, across far north Queensland, the Top End of NT and northern WA).

There are two further sub-options for the structure of the HFAs. The first is that the HFA is a Commonwealth agency that is part of DoHA. The second is that the HFA is established as a health portfolio agency separate from DoHA, under the Financial Management and Accountability Act (FMA) 1997. If under the FMA, HFAs would be accountable to the Minister but with a level of independence equivalent to that of other FMA agencies such as Cancer Australia, the NHMRC and the Private Health Insurance Ombudsman. This latter arrangement seems more appropriate given the role of the HFA to make commissioning decisions on behalf of the regional/state population.

Either way, the HFA structure will be better placed to balance provider and population interests, both geographically and in terms of population sub-groups. The size will need to be sufficiently large to manage and spread risks as well as small enough to allow for population planning and informed commissioning.

The regional HFAs plan, commission, fund and regulate health care providers in their region (within national standards, policies and budgets) on behalf of the Commonwealth. Thus the policy function of the states transfers to DoHA but the planning, commissioning and monitoring functions transfer to Commonwealth HFAs.

HFAs are allocated a population needs-adjusted share of health funding. They are accountable for health care for the regional population. They commission the full range of services from prevention to palliation to improve and maintain the health of the regional population. This includes responsibility for building coordination and integration of local health services. Attachment 2 outlines one aspect of population based funding, modelling the impact of equitable distribution of MBS funding.

These responsibilities imply the skill mix that will be required, much of which currently resides in state health departments and in existing regional and area health services. Regardless of whether Option 1(a) or Option 1(b) is selected, the commissioning body will require staff with expertise in health needs analysis, health planning and contracting. This includes expertise in building relationships and fostering the integration of local health services.

Medicare Australia continues to act as the transaction agent for MBS and PBS services, along with any additional payment roles the Commonwealth may allocate. The national MBS is retained but could be expanded over time to incorporate other types of payments.

HFAs negotiate contracts for health care provision with local service providers (public or private sector), addressing efficiency and volume risks. While the majority of funding is on the basis of outputs (eg casemix, MBS), contracts could also be on the basis of population-covered (eg health promotion) or funding-for-capacity (eg regional epidemiological surveillance).

A key difference between Option 1(a) and Option 1(b) is in the flow of funding. In Option 1(a) funding flows from the Commonwealth directly to providers either as retrospective payments for services rendered (MBS, PBS and so on) or as prospective contracts. In Option 1(b) each region receives a population needs-adjusted share of funding. The HFA then uses its regional funding allocation to pay for services rendered (MBS, PBS and so on) or to fund prospective contracts. In both Options 1(a) and 1(b) the responsibility for commissioning is separate from ownership and delivery.

States may choose to continue to manage their health services and hospitals, providing services as purchased by the Commonwealth. Alternately, they could corporatise their hospitals and health services along Canadian lines (ie through community or University-type ownership arrangements) such as is already the case for faith-based 'public' hospitals in several Australian states. These corporations might be individual health care facilities or networks of facilities. This would effectively turn public health services into not for profit non-government agencies, similar to Foundation Trusts in the UK. States could, of course, choose a combination of these two strategies. State health authorities would also retain some roles in accordance with statutory responsibilities (eg disaster coordination, public health emergency responses).

The UK Model: Foundation Trusts

In England, hospitals and related services are organised as Trusts, similar to area health services. Trusts can apply to become Foundation Trusts which are independent legal entities called Public Benefit Corporations. Foundation Trusts are free from central government and local health authority control but continue to deliver services to their local populations, as purchased by Primary Health Care Trusts and subject to national standards.

Foundation Trusts have more freedom to develop local solutions to health problems, including setting up partnerships with other health providers. Local residents and patients can become "members" of the Trust. Members can serve on the Trust Board of Governors along with representatives of staff and other stakeholders. Non executive directors on the Trust Board of Directors are appointed from amongst the Board of Governors.

The government maintains reserve powers including step in rights. The public assets involved are protected by prohibitions on demutualisation or privatisation.

Source: UK Dept of Health, 2005

The question arises as to whether commissioning as well as service provision could be contracted to non-government organisations (including private health insurers). This is an available option, and is canvassed in a separate commissioned paper on '*A Mixed Public:Private System for 2020*'. This option may be appropriate for example, for people with chronic and complex conditions who are assessed as requiring enhanced access to care and coordination. This would be a decision to be made by the Commonwealth, or by individual HFAs. Current risk adjustment technologies are not sufficiently robust to allow governments to contract out purchasing of *all* public care for partial populations (eg those with private health

insurance) because cost risk cannot be estimated reliably in advance. The exception outlined above is a population in which risk and likely costs have already been individually clinically assessed. Alternatively, it may be feasible to contract out purchasing for particular health programs for entire regional populations, but only if it were possible to avoid creating new cost- and blame-shifting opportunities at regional level.

Health Funding Authorities

In each of the three options for major structural reform, we suggest the use of regional Health Funding Authorities. Their structures, roles and accountabilities vary in each option, but the essential features are:

1. The HFA's mission is to plan, commission, fund and regulate the range of health care services that best meets the health care needs of the regional population, within the policies and budgets allocated by government.
2. To enable the HFA to focus on this role, it should not have operational responsibility for health care delivery, nor should it report to the health department that is responsible for broader government policy. It should report to the relevant Minister or Parliament in relation to its performance of its functions, and may be established by statute or regulation.
3. The HFA is made up of a board, appointed by the relevant Minister or Governor-In-Council, with the members being selected on the basis of expertise, including knowledge of the region and its health care needs.
4. The HFA, through its Chief Executive, employs people with skills in health planning, health care, health needs assessment, performance monitoring, finance, community and clinician engagement and data management.
5. The HFA supports and resources networks or other collaborative arrangements among the region's health care providers and representatives of their patients or clients and communities, to enable local approaches to integration and coordination of care to be developed, among other benefits.
6. The work of the HFA is supported by national health policies, standards, research and information, which guide its work and ensure national consistency in meeting agreed universal entitlements and standards.

Option 2: States take responsibility

This option is in many ways the mirror image of Option 1.

The Commonwealth transfers its share of funding for health and aged care to the states using a population needs-based funding formula. That formula is the responsibility of the Grants Commission and the funding is possibly encapsulated in a new kind of term-limited Health Agreement. A small proportion is retained for funding of national institutions (such as, for example, the NHMRC, AIHW and regulatory and national representative bodies). The Commonwealth retains roles required by the constitution (for example, health services for defence personnel and veterans) as well as its share of the national functions described above (policy, intelligence and information, standards, regulation). The Department of Health and Ageing continues to exist in a scaled down form, but most functions and staff are transferred to states.

States are responsible for planning, commissioning, funding and local regulation of health and aged care services. The budget for MBS, PBS and other Commonwealth funding programs is

transferred to the states, but MBS and PBS continue as national patient entitlement, categorisation and billing systems. Medicare Australia continues as the payer and processes claims on behalf of the states in the same way it now does for the Department of Veteran Affairs. The national MBS is retained but could be expanded over time to incorporate other types of payments.

As discussed in more detail in Attachment 2, states are required to meet all MBS and PBS claims made by their residents. Over time, states may decide to offer alternative funding methods to GPs, pharmacists etc, which they would fund by reallocating unspent funds from their MBS and PBS budgets (eg to enable different delivery arrangements in remote areas).

Table 5: Governance functions in the State option

Functions	Commonwealth	States	Private/NGO
Funding	Wholesale transfer to states. Medicare Australia maintained as payment agency for states/HFAs	Fund care delivery and other functions	As is
Ownership	As is	States may own but may not directly operate hospitals and health services	As is
Commissioning	Broad priority setting and facilitation of agreements for services that cross state borders	States commission public health services	As is
Provision	As is	Public health care providers may be corporatised. States contract with a range of providers.	As is, including as contracted by state health authorities
Regulation	National policy, standards, registration, regulation	State regulation	As is
Other issues	There is no incentive for the Commonwealth to maintain growth in its share of health funding if all responsibility is transferred to the states. Given predicted future needs, this option would only be viable if a strict funding formula for the Commonwealth contribution could be agreed.		

As with the Commonwealth model, there are two sub-options under the State model, with States free to decide which option to adopt. Either way, they are required to demonstrate that the commissioning and providing functions are effectively separated.

Option 2(a) - the State plans and commissions all health and aged care services

This is similar to Option 1(a) in the Commonwealth option.

Option 2(b) - the states (or at least the larger ones) establish regional Health Funding Authorities (HFAs) in order to fulfil the commissioning function

Under this option, the regional HFAs plan, commission, fund and regulate health care providers in their region (within national standards and policies and state plans and budgets).

The HFA is a state agency. In states where services are corporatised, the HFA is part of the state health department. In states where services are not corporatised, the HFA is a health portfolio agency under the relevant state legislation, with legal status similar to that of the existing state Health Care Complaints Commissions. This is designed to reduce the conflict of interest problem that currently exists for the states as both purchasers and providers.

As in Option 1(b), for larger states the HFA structure will be better placed to balance provider and population interests, both geographically and in terms of population sub-groups. The size will need to be sufficiently large to manage and spread risks as well as small enough to allow for population planning and informed commissioning.

HFAs are accountable for health care for the regional population. They commission the full range of services from prevention to palliation to improve and maintain the health of the regional population. This includes responsibility for building coordination and integration of local health services.

HFAs negotiate contracts for health care provision with local service providers, addressing efficiency and volume risks. While the majority of funding is on the basis of outputs (eg casemix, MBS), contracts could also be on the basis of population-covered (eg health promotion) or funding-for-capacity (eg epidemiological surveillance).

As with the Commonwealth option, these responsibilities imply the skill mix that will be required, much of which already exists in state health departments and in regional and area health services. Regardless of whether Option 2(a) or Option 2(b) is selected, the commissioning body will require staff with expertise in health needs analysis, health planning and contracting. This includes expertise in building relationships and fostering the integration of local health services.

Service provision remains as is or, in the case of state-owned agencies, could be corporatised to achieve the separation of commissioning from provision of care.

As with the Commonwealth option, a key difference between Option 2(a) and Option 2(b) is in the flow of funding. In Option 2(a) funding flows from the state directly to providers either as retrospective payments for services rendered (MBS, PBS and so on) or as prospective contracts. In Option 2(b) each region receives a population needs-adjusted share of funding. The HFA then uses its regional funding allocation to pay for services rendered (MBS, PBS and so on) or to fund prospective contracts.

The allocation of population based funding to HFAs offers the potential for HFAs to enter into arrangements that substitute for the underspending of MBS in some regions resulting from the undersupply of doctors and other health professionals (e.g. rural and outer metropolitan areas). Conversely, regions with high utilisation of MBS will potentially be underfunded for these service levels. The reconciliation of fee for service programs within population based budgets will present particular risks to states (which lack the fiscal capacity of the Commonwealth to absorb cost overruns) under this option. In any case, the obligation to continue to provide universal access for all Australians to medical services should be preserved (by inclusion in the National Health Charter or other means).

We note that this option could have the potential to 'let the Commonwealth off the hook' over time. The Commonwealth still needs to be involved because states do not have the tax base to allow them to fully take over funding responsibility. The design of arrangements to ensure

that the Commonwealth has an incentive to respond to growth in health care needs and technical capabilities with increased funding would be a major challenge, given that it would no longer have any accountability for health care delivery. One solution would be to use an independent indexation-setting body, similar to the Medicare Payment Advisory Commission (MedPAC) in the USA (MedPAC, 2008).

Option 3: Joint Commonwealth: State Health Commissions

This option involves the Commonwealth and each of the states establishing a third-party health authority to plan and commission health services in the state. Commonwealth and state funds for health and aged care are pooled and allocated to the Health Commission.

Table 6: Governance functions in the Joint Health Commission option

Functions	JHC/s	Commonwealth	States	Private/NGO
Funding	Receive pooled C'w and state funds	Wholesale to JHC. Medicare Australia maintained as payment agency for JHC/s.	Wholesale to JHC	As is
Ownership	No	As is	As is or corporatise	As is
Commissioning	All commissioning	Broad planning for equity and priority setting and facilitation of agreements for services that cross state borders	State based priority setting and planning targets	As is or as contracted (eg brokerage, care coordination)
Provision	No	As is	Public health care provision by states or by corporatised public agencies, or as contracted to private/ NGO sector	As is, or as contracted.
Regulation	Of provider performance	National policies and standards	State standards	As is or as contracted.
Other issues	While both levels of governments will share rather than split accountability to the community, transparent decision-making will be critical to prevent the development of a new form of blame shifting.			

The Health Commission takes responsibility for planning, commissioning, funding and regulating the delivery of health and aged care in that state. State and national health departments continue to exist in a scaled down form, to fulfil other responsibilities and to act as funders and contract managers for the Joint Health Commission, but most staff transfer to the Commission. The Commission acts as a board of directors, to whom the CE of the Commission reports. The Commission is responsible jointly to the state and to the Commonwealth for performance of its functions, and reports to both Ministers or Parliaments.

Providers remain as they are. States may choose to continue to operate as providers, or to corporatise their provider agencies. Medicare Australia retains its national payer role, with a national MBS that could be expanded over time to incorporate other types of payments. The

national functions outlined above (national health charter, policy, standards, intelligence and information, professional registration) are undertaken through AHMC and AHMAC or its successor organisations and DoHA.

As with the previous two options, there are two sub-options under the Health Commission model.

Option 3(a) - the Health Commission plans and commissions all health and aged care services for the state

This is similar to the Commonwealth and state options.

Option 3(b) - the Health Commissions (or at least those in the larger states) establish regional Health Funding Authorities (HFAs) in order to fulfil the commissioning function

Under this option, the HFA is, in effect, a regional office of the Health Commission. As under other options, the HFA structure will need to balance provider and population interests, both geographically and in terms of population sub-groups. The size will need to be sufficiently large to manage and spread risks as well as small enough to allow for population planning and informed commissioning.

The regional HFAs plan, commission, fund and regulate health care providers in their region (within national standards and policies and Health Commission plans and budgets). The skill mix required is the same as under the Commonwealth and state options.

Again, a key difference between Option 3(a) and Option 3(b) is in the flow of funding. In Option 3(a) funding flows from the Health Commission directly to providers either as retrospective payments for services rendered (MBS, PBS and so on) or as prospective contracts. In Option 3(b) each region receives a population needs-adjusted share of funding. The RFA then uses its regional funding allocation to pay for services rendered (MBS, PBS and so on) or to fund prospective contracts.

We note that under this option, it is difficult to assign clear accountability for health to an elected government. That is, the Commission option potentially removes the care delivery problems caused by split funding roles, but it may not really resolve the problem of split accountability of governments to the community.

What about a National Health Commission?

We considered but have not developed a national-level joint Health Commission model for fund-holding. The difficulties of coordinating the funds pooling for all states, as well as the Commonwealth, and then redistributing the funding, seemed insurmountable. The difficulties that the National E-Health Transition Authority (NEHTA) has experienced in achieving this in only one area are evidence of the size of this problem.

It would also appear as too monolithic in a context where some measure of devolution and local-level accountability is a more attractive direction. It is also the option which requires most attention to the problem of scope – see the *Scope* section below.

There may, however, be a role for a National Health Commission as a joint Commonwealth and state body responsible for national policy and planning and for setting the national

framework within which any of the governance options would operate. This possibility is taken up in the *Common features* section below.

Option 4: Renovate

Under this option, the existing structures of Commonwealth and state health authorities are not radically altered. This 'renovation' option might be seen as the end point. Alternatively, it might be a development path to one of the other options. For example, the next round of AHCAs might be designed to achieve the renovation option, with a provision to make more structural changes which would entrench successful reforms in the subsequent ACHA (2014-2018).

Either way, the focus is on developing better specification and some 'teeth' for accountability (financial and public reporting measures), and the incremental development of reform in high priority areas. In this option, the parties agree on a case by case basis to pool funds or shift accountabilities in three major categories of reform:

- assigning accountabilities for service performance in specific areas to one level of government. This option has already been proposed by the Commission in its first report and was summarised above. As outlined in the Commission's first report, the assignment of accountabilities does not imply an immediate transfer of functions between governments. Nor does it imply that financial responsibility would fall on only one level of government. Rather, these arrangements would be designed so that each level of government carries clear political (and bureaucratic) accountability for meeting the public's expectations in specific areas of health service delivery. Under such an arrangement, failure to achieve performance benchmarks could result in both financial penalties and political consequences. As one example, the Commonwealth could be exposed to the costs that hospitals incur in meeting the needs of people with chronic disease who could have been treated in the primary care sector. The technology to identify admissions in this category and measure the incidence would need to be developed, but this is technically feasible. It would reduce the perverse incentives for both levels of government arising from the current splits in responsibility.
- better integration or coordination of care for specific populations (such as the frail aged, Aboriginal and Torres Strait Islander communities and others living in remote communities as well as those with specified conditions).
- the reform of governance and funding arrangements for specific sectors or for specific functions of the care delivery system. Examples of these might include primary health care, mental health, aged care or information and communication technologies (ICT).

As these categories imply, some of these renovation options may involve fine-tuning while others would constitute more fundamental reform of a specific aspect of health care.

Fee-for-service remains the dominant mode of payment for general practice and private specialist care, and the Primary Care Strategy adjusts arrangements for payment for allied health services, and related changes in the gate-keeping role of GPs. Over time, the parties could agree to changes in the funding for primary care designed to enhance the comprehensiveness and accessibility of care, such as per capita payments for enrolled populations with high primary care needs. Other opportunities for renovation are identified

over time through existing structures such as AHMC and AHMAC and through current national initiatives including the work of the NHHRC, the National Prevention Taskforce, the Primary Care Strategy and so on.

Under these arrangements, the Commonwealth could, for example, make agreements with individual states to take over financial responsibility for all care of those older people and people with disabilities who have high care needs. Equally, the Commonwealth could move to simplify its own funding programs, in addition to the current work to reduce the number of Specific Purpose Payments to the states.

This option is intended to enable preparation for transition to more fundamental reform, based on the results of incremental change as outlined above. A significant reworking of the Australian Health Care Agreements is the main immediate instrument to enable this option. Such new AHCA's will need to include commitments to reform in high priority areas and to the goal of moving to single-point accountability. Clearer incentives and sanctions to reinforce the accountability of both the Commonwealth and the states for achievement against the agreed reform agenda will also be needed. The next AHCA's would then be designed to achieve the renovation option, with a provision to make more structural changes which would entrench successful reforms in the subsequent ACHA (2014-2018).

But there is no need under the renovation option for reform initiatives to be limited to those agreed in a five year health agreement. Renovations can occur whenever the Commonwealth and the relevant state agree on a required reform. Likewise, the Commonwealth can also take unilateral action for major reform in those areas where it currently has responsibility such as reform of the primary health care program. This process could enable testing of options to achieve single point accountability.

Strong policy leadership and sustained cooperation among health authorities will be required. The flexibility for different developments in different jurisdictions is a potential strength, but remains dependant on Commonwealth preparedness to accommodate such flexibility. Commonwealth and state health authorities will necessarily be the main negotiators of such changes. However, it may be helpful to open up the negotiation process because those working in the health authorities have a conflict of interest when changes in health authority roles are on the table.

The five governance functions are shared more or less as is, as summarised in Table 7 below.

Table 7: Governance functions in the renovation option

Functions	Commonwealth	States	Private/NGO
Funding	Status quo except as agreed jointly with one or more states	Status quo except as agreed jointly with the Commonwealth	As is
Ownership	Status quo except as agreed jointly with one or more states	Status quo except as agreed jointly with the Commonwealth	As is
Commissioning	Status quo except as agreed jointly with one or more states	Status quo except as agreed jointly with the Commonwealth	As is
Provision	Status quo except as agreed jointly with one or more states	Status quo except as agreed jointly with the Commonwealth	As is
Regulation	Status quo except as agreed jointly with one or more states	Status quo except as agreed jointly with the Commonwealth	As is
Other issues	This is an attractive option in being relatively less threatening to existing interests and arrangements, and enabling potential structural change to be tested incrementally. The down-side is a perception that the promise of the reform process in the end may amount to simply 'more of the same'.		

Common features

In developing the options above, it became apparent that some functions and features did not change between options:

A national health charter

Regardless of the option selected, there should be a national statement of entitlement, signifying that all Australians will have access to certain agreed forms and standards of care. The statement should be developed over time, based on a combination of knowledge about what works, and agreement that it should be available to all. We would suggest it start with such basic measures as universal mother and baby health care, access to primary clinical care, and support for people with disabilities including those caused by ageing. It should incorporate a statement that gives more concrete shape to the concept of 'people and family centred care'. Such a statement could be an important foundation for the health system's response to the call to close the health gap between Indigenous and non-Indigenous Australians. Responsibility for developing and maintaining the national health charter could be taken by an existing body like the NHMRC or the AIHW, or a new body (perhaps a National Health Commission) could be established for this purpose. It should be accountable to AHMC or its equivalent.

National policy and planning

In all options, capacity for national policy-making and planning should be sustained under the auspices of AHMC and AHMAC or its successors. High priority policy areas, for example, Aboriginal and Torres Strait Islander health or mental health, could be nationally specified and their budgets and service arrangements protected. Further, regardless of the option adopted, there will be a need for ongoing reform and development of the health system once the work of the current Commission is completed. That ongoing development needs to be undertaken under the auspices of AHMC and AHMAC or its successors.

National health intelligence and information

Australia is well served by some of its national health institutions, and given its size could be well served by national strategies in important areas like information and communication technology for health. National health data are improving, and governance change should disrupt this progress as little as possible.

National regulation

Similarly, we need to sustain our capacity to standardise some regulatory arrangements across the country, such as the Aged Care Accreditation and Standards Agency, and nationally harmonised registration of health professionals.

Regional planning and delivery

In all of the options above, we suggest that there must be the option for better regional coordination and planning of health care delivery. The

questions of the size of regions, and their relationship to state boundaries, vary under various options. Regions could carry specified accountability and budgets for national policy priority areas (like mental health).

Strengthen primary health care and improve the integration of 'health' and 'aged' care

There is a critical need to strengthen primary health care. Likewise, there is an urgent need for better integration in the planning and financing of 'health' and 'aged' care to stop the cost and blame shifting that now occurs and to improve the coordination of care for those with chronic health needs. These two problems need fixing under any option. See Attachment 3 for a more detailed discussion of the impact of the options for primary health care.

Change is a process

Change should be staged, and higher level enabling measures should be put in place first, so that those closer to patient care and community needs are supported to enhance the effectiveness of their work, while also being able to continue care delivery with a minimum of disruption.

Funding of Indigenous Primary Health Care

The current problems in governance of the Australian health system are magnified in the funding and regulation of Aboriginal and Torres Strait Islander health care. In particular:

1. The fee-for-service funding of general practice and pharmacy care contributes to access problems (especially but not only in rural and remote areas). Indigenous people aren't able to get anything like a 'fair share' of MBS- and PBS-funded services (Deeble et al, 1998; Dwyer, Silburn and Wilson, 2004).
2. Efforts to pool funds between the Commonwealth and states are impeded by all the problems of multiple players with different agendas and priorities, so that good intentions and good ideas like the Primary Health Care Access Program (PHCAP) fail in implementation.
3. Dollar for dollar, Indigenous health care providers face a heavier burden of managing multiple contracts and complying with multiple reporting requirements than other primary care providers (Source: unpublished Victorian data).

For these and many other reasons, Aboriginal and Torres Strait Islander people use less primary care, and experience higher rates of hospitalisation, than any other group. This could change if Commonwealth and state governments could agree on a workable role definition, resolve the arguments about who pays for what, and implement a new approach in partnership with communities.

Scope

There are important problems with defining the scope of health and aged care reform – problems of policy and the problem of current jurisdictional variations in the scope their health or human service portfolios. The policy problem is that, for example, services for people with disability and for families and children need their own high level focus, and can suffer from being ‘bundled up’ with the relatively larger health and aged care sector.

Currently, jurisdictions vary widely in their portfolio arrangements. Victoria, Tasmania and the Northern Territory have existing broader boundaries on their human service authorities – including variously housing, family and community services. Similarly, ambulance services are not included in the health portfolio in some states, but rather in emergency services. Likewise, prison health services may be part of the health portfolio or part of the justice portfolio.

Jurisdictions may choose to take the opportunity of health and aged care reform to realign portfolios. However, requirements for portfolio changes can be largely avoided in all options (the national Joint Health Commission is perhaps the exception, but we have rejected this option for this and other reasons). The departments with larger scope already manage multiple joint agreements and the equivalent of this arrangement could continue.

Private and non-government sectors

This paper raises several issues of relevance to the private and non-government sectors, in particular, their roles in providing health and aged care, and possibly in acting as contracted purchasers. In this section, we briefly address the implications for the private and non-government sectors, noting that the Commission has commissioned a separate paper which canvasses existing and potential roles for the private sector more fully.

Private health insurance (PHI)

The role of PHI does not need to change under any of the options. However, the NHHRC is separately considering the role of PHI and, in that context, there are a number of possibilities. One option is the potential for PHI to act as purchaser/commissioner for its members on some form of ‘cash out’ basis, for example, the funding of care packages for identified patient groups in relation to chronic and complex care. As noted above, such an approach would be possible under all of the options in this paper.

Private hospitals

The role of private hospitals is not necessarily changed by any of the options, but under all options, private hospitals could become more involved in providing care for public patients or for responding to contracting opportunities to provide a broader range of care.

Non government organisations

There is an enormous array of non-government organisations involved in health care provision, from large national church-based hospital groups to local support services for those with a specific condition. Their roles are not necessarily changed by any of the options, but more effective commissioning and transparency of funding will enhance their opportunity to participate and to contribute to local health solutions involving new models of care. In

addition, better tendering and contract management practices have the potential to improve both efficiency and responsiveness of the care provided by NGOs.

Chronic and Complex Care

As we have already noted, the current health system works well for episodic care, but less so for those with complex chronic conditions. Most of the solutions lie outside hospitals and many involve private and non-government providers. Under all options, there is potential for private and non-government providers to take on care coordination roles for an enrolled population.

Private Sector Participation in System Governance

Under the current arrangements, while private providers and funders are a major part of the health system, they do not have a place at the table in national governance forums such as AHMC or COAG. These groups are rather regarded as stakeholders who need to be managed through the political process. Private/non-government health and aged care entities primarily relate to the system governance structures as lobbyists, and as industry and professional associations.

Priority areas for system redesign include care coordination outside hospitals as well as the creation of an effective interface between hospital and community based care.

Commonwealth/state arrangements cannot address the care delivery aspects of these changes, as the community based providers are largely private. The private sector needs to play an active role in system redesign, and it could be argued that it therefore needs a larger role in system governance.

The various structural options outlined in this paper assume that with the separation of commissioning and delivery there will be greater opportunities for local participation and integration by private providers at the local level.

The question remains as to whether there should be provision in national, state and regional governance arrangements for these private participants (provider organisations, professional associations, industry bodies and private health insurers) to contribute their expertise. In Germany, for example, the Concerted Action model seeks to engage all participants in the reform process (Gross, 2008).

Conclusions: Can we get there from here?

We have outlined the problems, assumptions, principles and design considerations which formed the basis of our thinking, and have outlined four distinct feasible options.

We have not expressed a view about which is the best option, and to do so is not our role. However, we have reflected long and hard about the major problems to be solved, the potential for change, and the attendant risks. We would offer the following thoughts for consideration by those who will make decisions about these critical matters.

1. System design is not a set of free choices

Elements must be aligned: policies, funding arrangements, skills, roles and accountabilities come as a linked set, and each element affects all the other elements in sometimes unpredictable ways. The need for change arises precisely because of the current lack of such alignment. Whatever is done in future must achieve better alignment and cannot run the risk of being perceived as just a continuation of business as usual.

2. Incrementalism is an enduring feature of Australian public policy

The most achievable pathway may be what we have called the renovation option. It could be adopted explicitly as a transitional arrangement, and we have attempted to outline the main features in a way that would enable this strategy. However, we cannot honestly suggest that the continuation of the kind of split responsibility the system currently endures is a platform for improved accountability and more effective governance. If this option is adopted, it should include provision to begin experimenting with integrated responsibility for those sectors of care which most urgently require change, that is, improvement in health care for Indigenous Australians, and ongoing care for people with complex and chronic conditions.

3. Whatever the governance option, there is room for simplification in the current plethora of funding programs at all levels of government

This could be undertaken through sophisticated methods of harmonising payment arrangements regardless of source. The same harmonisation strategy could be adopted for accelerating changes to reporting and information sharing arrangements. That is, change could happen in the funding and information management 'back room' that would move the blame- and cost-shifting borders away from patients and care providers and minimise, if not resolve, the care delivery problems they cause.

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Attachment 1: Technical Issues

As well as setting out two primary questions for this paper, the National Health and Hospitals Reform Commission asked us to consider a number of technical issues, only some of which we have addressed above. We give further brief responses to each below.

1. Purchasing

The Commission noted that ‘the purchasing function is relatively poorly developed and to the extent that it exists, has been associated with the evolution of more sophisticated ways of funding (eg through casemix funding arrangements) with attention to more detailed specification of the range of services to be purchased being limited to some specialised areas. The paper should identify whether a more sophisticated purchasing function should be encouraged to evolve in Australia and if so, what might be the benefits of this policy direction, the feasibility of this and impediments to the development of such a strategy. The options paper should also identify the merits or otherwise of a clearer separation of funding/purchasing and provision in the Australian health system.’

We have addressed the commissioning function in the body of this paper. In relation to technical purchasing options, it is not currently feasible to replicate the sophisticated definition and costing of hospital episodes in other parts of the health system. Even if a significant development investment is made tomorrow, it would be many years before an episode-based (rather than item-based) classification and costing system would be possible. That said, we note that health authorities working with providers have developed sophisticated service models and used them as the basis for payment regimes in areas of policy focus, including mental health and disability care. Other opportunities have been lost, including the potential to gather more useful health intelligence from GP and specialist billing codes (eg the description of services as ‘short’ ‘medium’ or ‘long’ consultation is no basis for developing an episode based classification and funding model).

We suggest that better specification of funded care, and better information about utilisation of services, should be pursued selectively, where technical means and policy importance combine to provide opportunity for benefit.

2. Funding for accountability

The Commission suggested that there are two broad choices in methods of funding for accountability: ‘to emphasise area funding or activity-based funding (or both). Some canvassing of the strengths and weaknesses of each approach should be undertaken. Here the paper needs to consider issues both in terms of how public sector services might be best structured, but also structures, governance and accountability arrangements might evolve in the context of so-called ‘funds pooling’ options.’

This paper has focused on arrangements for the governance and accountability of government, rather than providers of care. We suggest that both area or population-based funding and activity-based funding are important and valid methods for accountability, and that the choice of method depends on the policy goal, the level at which the funding is flowing and the alignment of the delivery system. For example, area-based funding is more effective

when one organisation has authority over most of the services in the area, or at least coherent packages of services while activity-based funding is more appropriate for the funding of specific services such as a hospital. While activity-based funding promotes technical efficiency, population-based funding promotes allocative efficiency. For this reason, models that contain elements of both, if well-designed, have the potential to contain the best incentives.

3. Integration of organisational structures

'States differ in terms of whether public institutional provision is integrated at an area level and whether hospitals are organisationally distinct entities from other health services. Discussion about the merit or otherwise of integrated organisational structures should be included in the options paper.'

We are mindful of the extent to which restructuring of public health care institutions has been a cyclical and very expensive exercise over the last 15 years. We also note that almost all public sector organisations (ie the health authorities of most states and many organisations within Victoria) are larger and/or operate with less effective delegation of operational authority than the evidence from research on organisations indicates is feasible or desirable. We would therefore suggest that restructuring of public health care organisations be undertaken only when there is a strong basis of need to do so, and that it should move either in the direction of reduction in size or enhancement of the strategy known as 'divisionalising' in large corporations (ie operational autonomy for different product or service lines within a large organisation). The general principle should be to decentralise what you can and only centralise what you have to.

4. Breadth of health authority roles

'Jurisdictions also differ in terms of the scope of their health authority's responsibilities (e.g. some 'Human Services' departments are responsible for much more than health services). Although primarily determined by whole of government considerations as part of machinery of government changes, some comment should be included in the options paper on whether a broader range of functions has merit in terms of taking the claimed comprehensive view of health and the range of appropriate health interventions, set against the added complexity of management of the Department and span of control issues.'

We have briefly addressed this question in the section headed 'Scope'.

5. The role of Boards

'If a funder/purchaser versus provider split is proposed, the options paper should canvass whether such a split necessitates the introduction of boards of directors of the provider organisations. The strengths and weaknesses of boards in the health sector, their role, and the nature of any autonomy that should be accorded to boards should be canvassed.'

Australia has had two types of boards, hospital and community health centre boards and area health boards. Hospital and community health centre boards have been historically

responsible for managing the budget allocated by government. Area health boards were historically responsible for improving the health of residents in a designated geographic area and, *to that end*, were also responsible for the management of health services. Area Health Boards, particularly in NSW under the Area Health Services Act 1986, had real governance authority and accountability. Movement away from models offering a measure of geographic area responsibility and devolved funding (through a series of amalgamations) has occurred in recent years (except in Victoria) because of perceived administrative and political difficulties rather than health policy or efficiency concerns. Given the plethora of administrative changes in recent years, we take the view that boards should only be reinstated with appropriate authority guaranteed or in the fully realised form of corporatisation.

Attachment 2: Improving equity of access to MBS and PBS

While current fee for service arrangements work well for some, there is significant inequity across the country in relation to geographic access to these schemes. These inequities largely reflect the geographic maldistribution of the medical workforce, both between and within states and territories. In this short attachment, we explore a single proposition – that is, that better geographic equity of access to medical care could be achieved through a shift to population needs-based funding while still using MBS and PBS as payment mechanisms. This analysis does not address overall geographic equity, so that, while it appears from this analysis that residents in some states use more MBS and PBS funded services than others, analysis of other sectors of the health system (for example, hospitals and mental health services) would produce different results.

Table 8 illustrates current inequities at the level of the states and territories. With average benefits of \$1,010 per person in 2007/08, NSW residents received \$80 per year more benefits from these two schemes than the national average. At the other extreme, NT residents received \$508 less. The differences are even more extreme when per capita benefits are examined at the level of urban, regional and remote region of residence.

Table 8: Per capita MBS and PBS funding by state and territory 2007/2008

Jurisdiction	MBS and PBS per capita	Per capita difference from national average
NSW	\$1,010	\$80
SA	\$957	\$27
VIC	\$941	\$11
TAS	\$909	-\$21
QLD	\$892	-\$38
WA	\$787	-\$143
ACT	\$739	-\$191
NT	\$423	-\$508
Australia	\$930	\$0

Source: Medicare Australia (MBS and PBS data) and ABS (population data)

In discussing the options for reform and renovation, we noted that needs-based funding to regions is critical to achieving better geographic equity. This short attachment summarises how this might be achieved.

It would be neither possible nor desirable to simply reduce MBS and PBS funding in NSW, South Australia and Victoria and redistribute it to the other states. Both schemes are designed to be universal schemes and Australians are entitled to access them wherever they live (presuming that they are available). Further, there is no evidence to suggest that those states enjoying benefits above the national average are 'over-serviced'. Indeed, the Commission is receiving significant input suggesting that increased investment in primary care will be required to meet Australia's future needs.

Instead, achievement of geographic equity whether via regional HFAs or by other means will require increased investment over time. While regional HFAs would initially be established by

cashing out the region's current level of benefits (with the majority of funds continuing to be paid as fee-for-service benefits through MBS and PBS), funding for those regions below needs-adjusted per capita share would gradually be increased (potentially over some years) to an equitable level.

Table 9 illustrates the potential cost of increasing per capita benefits across the country to the level of that enjoyed in NSW. In total, MBS and PBS benefits would need to increase by \$1.7 billion or 8.6%. This represents an increase in total health spending of around 1.8%, which is well within the growth rate in health expenditure experienced in recent years. It is thus a feasible option. It is important to note that any actual adjustments would be balanced by adjustments in expenditures on other programs, which may also account for some of the variability between states in population take up of MBS and PBS. Also, within-state variations are in many cases more significant, and will need to be addressed at regional level under any option if equity of access is to be improved.

Table 9: Investment required to achieve equity (unadjusted for need) between the states in MBS and PBS funding (2007/08 dollars)

Jurisdiction	\$ required to increase MBS and PBS to NSW level	% increase
NSW	\$0	0%
SA	\$84,125,206	5.5%
VIC	\$359,910,356	7.3%
TAS	\$49,767,845	11.0%
QLD	\$496,545,915	13.2%
WA	\$473,919,055	28.2%
ACT	\$92,209,318	36.6%
NT	\$127,777,533	139.0%
Australia	\$1,686,577,811	8.6%

Within their regional allocation, each HFA would be required to continue to cover the costs of universal access to both the MBS and the PBS for their residents. This is essential to maintain the rights of citizens to access these services. But if a region is underspent (e.g, because of the undersupply of doctors and other health professionals in rural and outer metropolitan areas), the HFA could enter into arrangements to develop new models of care that substitute for the underspending. Conversely, regions with high utilisation of MBS/PBS could potentially be underfunded for these service levels, but only if growth in MBS and PBS funding is not maintained.

Either way, there would be no requirement for the HFA to 'silo' their MBS or PBS funding. The HFA will have access to a global allocation for their region's residents that includes not only MBS and PBS funding but also, for example, funding for hospital and other services. Within this global allocation, the HFA is charged with responsibility for funding the range of services required to meet the health needs of their residents. In doing so, they will need to take account of population need, the requirement to maintain the universality of Medicare, the range and mix of services already in place, opportunities for service substitution and new models of care.

Attachment 3: What the options mean for primary health care

This section provides just one example (primary health care) to illustrate what the options mean in practice. Primary health care services are first point of contact services that do not require a referral from another health professional. They include, but are not limited to, GPs, community health, home and community care, maternal and child health, community mental health, aged care assessment teams, aboriginal community-controlled health services, dentistry, optometry, other allied health services.

Under Option 1, primary health care services would be funded and either reimbursed or commissioned by the Commonwealth. Under Option 2, primary health care services would be funded from a funding pool that includes both Commonwealth and state contributions, but they would be reimbursed or commissioned by the state. Under Option 3, they would also be funded from a funding pool that includes both Commonwealth and state contributions but would be reimbursed or commissioned by a joint Health Commission. Under all options, individual out-of-pocket payments for services would continue to apply, unless alternative decisions were made to allocate public funding or change health insurance scope.

To successfully meet Australia's future needs, the level/s of government given responsibility for primary health care services in the future will need (among other challenges) to:

- increase the size and mix of the primary health care workforce
- achieve a more equitable geographic distribution of the primary health care workforce
- develop and implement funding models that achieve the right balance between fee for service, capitation, salary, funding for capacity and funding for performance
- use available incentives and levers to achieve better planning, coordination and integration of primary health care services
- use available incentives and levers to achieve better linkages between primary health care services and other parts of the health system, including incentives to keep the population healthy and thus reduce reliance on acute care hospitals and residential care.

These challenges are summarised in Table 10 along with brief comments about the options set out in this paper.

Table 10: Reform priorities for primary health care

Challenge	Comment
Workforce	Attention to future workforce supply and roles is needed regardless of the option. There is no evidence to suggest that any particular option will better support workforce supply and distribution. However, the Commonwealth has the deepest pocket and the best opportunity to shape the volume and mix of health professionals graduating from Australian universities
Equity	The states have a better (although somewhat patchy) track record on this issue. Needs-based funding to regions is critical to achieving better equity regardless of the structural option
Funding models	While there is no doubt an ongoing place for fee for service payments, it is equally

Challenge	Comment
	true that fee for service alone is not an adequate funding model for primary health care. There are opportunities under all options for better blended and mixed payment models similar to those in place in other countries (eg, the funding of New Zealand Primary Health Organisations)
Planning and coordination within primary health care	More comprehensive, and more effective, local solutions are required. All integration is local and thus regional structures are essential, regardless of the structural option. The states have a better (but again somewhat patchy) track record on this issue.
Planning and coordination with other parts of the health system	This requires both effective funding levers and local planning and coordination structures and processes. There are opportunities under all options that involve regional HFAs for better planning and coordination of services on a regional and local basis. It is doubtful that this could be achieved under any of the centralised options

As this brief summary illustrates, a change in the corporate governance of the health system (regardless of the option selected) will not, by itself, solve the problems confronting primary health care, just as none of the options immediately solve the problems confronting other sectors. Each of the options creates opportunities (in different ways) to removes barriers, set directions and change the way that resources are allocated. The key question is to design the governance structure that is most likely to allow these challenges to be addressed.