Summary of the Council of Australian Governments Agreement: National Health and Hospitals Network

The following is a summary by Health Consumers Queensland (HCQ) of the agreement reached at the Council of Australian Governments (COAG) meeting on 19-20 April 2010 in relation to a National Health and Hospitals Network.

The COAG Agreement outlines structural reforms for the Australian health system, and sets out the framework for the National Health and Hospitals Network.

Western Australia is the only State which is not a party to the agreement. Discussions between the Commonwealth and Western Australian Governments will continue.

HCQ has endeavoured to summarise the COAG Agreement while remaining faithful its overall content and wording. The full Agreement is approximately 57 pages and can be viewed at http://www.coag.gov.au/ .

This summary also includes (in shaded boxes) issues identified by HCQ which arise for health consumers. These issues reflect HCQ's past submissions to the Commonwealth and Queensland Health Ministers, which can be accessed at HCQ's website www.health.qld.gov.au/hcq . In identifying these issues HCQ has liaised with other consumer and community stakeholders and appreciates their input.

The provisional work plan agreed to by COAG as part of the Agreement is also attached. Senior State/Territory and Commonwealth officials will develop a final work plan for implementation of the reforms, for agreement by COAG out-of-session by 30 June 2010.

HCQ understands the Queensland Government is establishing a Cabinet sub-committee, CEO sub-committee and a Health Reform Implementation Unit to commence implementation of the reforms.

A. Key reforms detailed in the COAG agreement

The Commonwealth and State/Territory Governments (except for Western Australia) have agreed to:

- The establishment of a National Health and Hospitals Network.
- Commonwealth investment of $5.4 billion in health reforms (see **Attachment A**). Queensland will receive approximately $4 billion over the next decade (see **Attachment B**).
- Full Commonwealth policy and funding responsibility for General Practice, primary health care and aged care.
- The Commonwealth Government assuming dominant funding responsibility for public hospitals (60 percent).

The reforms will start to take effect from 1 July 2010.

B. Role of the Commonwealth and States/Territories (excluding Western Australia)

The **Commonwealth Government** will**:**

- become the majority funder for public hospitals nationally (60 percent of the national efficient price);
- have full policy and funding responsibility for primary health care and General Practice; and
- have '*full funding, policy, management and delivery responsibility for a national aged care system'*.

The Commonwealth Government's role in relation to Local Hospital Networks (LHNs) is discussed below under 'Local Hospital Networks'**.**

The **State and Territory Governments** will:

- be the systems-managers of LHNs, which includes determining:
  - the boundaries for LHNs (in consultation with the Commonwealth); and
  - the selection, appointment and remuneration of LHN Governing Council members (**see Part D below**);
- be responsible for system-wide public hospital service planning and policy;
- purchase public hospital services from LHNs under LHN Service Agreements (**see Part D below**);
- be responsible for system-wide capital planning and management;
- own existing and new public hospital capital/assets;
- support the Commonwealth Government's takeover of primary health care and General Practice; and
- continue funding public hospital services (40 percent) and some primary health care excluded from transfer to the Commonwealth.

C. Funding

- The reforms will be funded through an agreed amount of GST revenue (to be retained by the Commonwealth and allocated to the States from 1 July 2011); funding under the National Healthcare Specific Purpose Payment (healthcare SPP) and additional Commonwealth funding of a minimum $15.6 billion between 2014-2015 and 2019-2020.
- The Commonwealth will fund 60 per cent of:
  - the national efficient price of public hospital services;
  - recurrent research/training expenditure;
  - block funding to regional/rural public hospitals; and
  - capital expenditure.

Over time it will fund 100 per cent of the national efficient price of 'primary health care equivalent outpatient services' to public patients.

- The States/Territories will fund the remaining 40 per cent of services/expenditure.

- An **independent National Health and Hospitals Network Funding Authority** will be established. It will be responsible for a National Health and Hospital Network Fund into which the Commonwealth's funding contributions (60 per cent) for the national efficient price of public hospital services for public patients will be paid.

  Joint Governmental Funding Authorities (for which the Commonwealth and States will be jointly responsible) will be established in each State. The Funding Authorities in each State will receive the Commonwealth's share of funding from the National Funding Authority, and will directly receive the State's contribution (40 per cent). The State Funding Authorities will distribute the combined Commonwealth and State funds to each LHN on the basis of activity based funding (taking into account the number and type of cases).

  At least one member of the National Funding Authority (to be comprised of five members, a Deputy Chairperson and a Chairperson appointed by COAG) will have regional and rural expertise.

- A State-managed fund will be established to directly receive Commonwealth funding for services including:

  - research/training;
  - block funding for agreed functions/services to support regional/rural public hospitals; and
  - capital investment.

- The efficient price for services will be determined by an **Independent Hospital Pricing Authority**.

- Regional and rural hospitals will be additionally funded for 'agreed functions and services and community service obligations' through block funding under a COAG-agreed funding model.

D. Key features of Local Hospital Networks

Role and responsibilities

These include:

- LHN staff employment (pursuant to employment/remuneration conditions established by the State in its workplace relations agreements);

- Implementation of national clinical standards;

- Local clinical governance arrangements;

- Informing the States of service levels delivered to facilitate Commonwealth funding;

- Maintaining financial and performance accountability;

- Negotiating LHN Service Agreements with the State Government;

- Operational and financial responsibility for their network;
- Developing the LHN's strategic plan;
- Implementing an operational plan for service delivery; and
- Receiving Commonwealth funding for service delivery, as agreed in the Service Agreement.

LHNs will work with PHCOs through formal engagement protocols.

Structure

- LHNs will be separate statutory entities established by State legislation.
- LHNs may comprise single or small groups of public hospitals, with a geographical or functional connection. In regional and rural areas the LHN structure will be tailored to the needs of those communities.
- LHNs to directly manage hospital services, and delivery of other services (at the discretion of the States).
- Common geographic boundaries with PHCOs will be established 'wherever possible'. It is expected '*There will be at least as many LHNs as PHCOs'*.
- Boundaries for LHNs will be determined by the States in consultation with the Commonwealth; PHCO boundaries will be determined by the Commonwealth. LHN boundaries will be finalised by Ministers by 31 December 2010.

Governance and appointment of Governing Councils

LHNs will comprise a professional Governing Council and Chief Executive Officer (CEO).

Members of the Governing Council will have expertise in health, business and financial management; clinical expertise; be representative of universities, clinical schools and research centres (where appropriate); and have other skills/experience (where appropriate).

(HCQ notes the Commonwealth Government's commitment to no new bureaucrats being appointed as part of the reform process).

Councils will be established through a public recruitment process. The '*need to ensure some local community knowledge and understanding'* will be considered when determining the membership of the Governing Councils.

States will determine remuneration rates of members. The State Health Ministers will appoint Governing Council members. The CEO will be appointed by the Council, with the State Health Minister's approval.

Responsibilities of the Governing Council and CEO will include:

- Effecting the LHN's Service Agreement through delivery of services and performance standards within budget;
- Ensuring accountable and efficient service provision;

- Monitoring LHN performance against the LHN Service Agreement;
- Responding to systemic issues and improving patient outcomes; and
- Communication with the State and relevant stakeholders, including the community.

Accountability

LHNs will be accountable through the Performance and Accountability Framework (further details are provided in **Parts G and H** below).

Role of the States

The States will be responsible for 'system management' of LHNs, including system-wide (state-wide) public hospital policy and service planning, as well as system-wide capital planning, and responsibility for the overall management and support of state-wide LHNs. State Governments will own hospital capital and assets.

The States will be the sole purchaser of public hospital services through LHN Service Agreements (see 'Funding' below). The Commonwealth will have no role in the agreement, negotiation or implementation of LHN Service Agreements.

The States will be responsible for remuneration and staffing (selection/appointment) of the Governing Council of LHNs.

Role of the Commonwealth

The Commonwealth Government will fund 60 per cent of public hospital services. It will pay into a State-managed fund monies for research, training and block funding (for functions/services including support of small regional/rural hospitals). It will also pay States for Commonwealth-funded primary health care services.

The Commonwealth will have no role in relation to LHNs other than providing 60 per cent of their funding.

Funding

The Queensland Government will purchase services from the LHNs under Service Agreements between the LHNs and the State.

LHNs will be funded by both Commonwealth and State Governments according to the services provided by each individual LHN under its Service Agreement with the State. The funds will be distributed to each LHN by the Funding Authority in each State/Territory.

The States will advise the Commonwealth of the funding agreed to in each LHN Service Agreement so that the Commonwealth can arrange for the necessary Commonwealth funds to be allocated to each Funding Authority from the National Health and Hospitals Fund.

Relationship between LHNs and PHCOs

- Common boundaries ('wherever possible') with at least as many LHNs and PHCOs.
- Formal engagement protocols between LHNs and PHCOs to be established by the LHN Governing Councils.

Consumer Engagement

LHNs will engage with '*the local community and local clinicians to enable their views to be considered when making decisions on service delivery at the local level, or service and capital planning at the state or territory level*'.

The Council and CEO will be responsible for functions including '*maintaining effective communication with the State and relevant local stakeholders, including clinicians and the community*'.

Issues for HCQ

1. Role of consumers

There is a lack of clarity around levels of consumer and community engagement in relation to the operation and administration of LHNs (service planning, infrastructure planning and specific program planning). Clarity is also required around the role consumers will have, the extent will they be involved in the LHNs' activities, and how consumers will be engaged.

Consumers must have an equal voice in LHNs, PHCOs and health systems and service delivery. Effective community and consumer engagement is vital in ensuring understanding of local health care needs and identifying service gaps. Accordingly, consumer representatives should be included as a category of member eligible for appointment to Governing Councils, with each Governing Council comprising at least one consumer representative.

The agreement appears to suggest that consumer engagement with LHNs will be restricted to decisions about service delivery at the local level, and service/capital planning at the State/Territory level. Consumer engagement should not be limited to decision-making around service delivery and service/capital planning. Rather, consumers should be engaged in a meaningful way to contribute to a range of LHN issues and decision-making processes.

A national consumer engagement framework should be implemented to guide LHN and PHCO engagement practises, and to ensure consumer perspectives are provided and considered in relation to health policies, programs and services.

2. Governing Councils

There is a need for national consistency in the recruitment, selection, appointment and remuneration of Governing Council members. Uniformity could be attained through the development of national guidelines to govern the selection criteria, processes, roles/responsibilities and remuneration of LHN Governing Council members.

Given issues raised by Health Community Councils in Queensland the level of remuneration for Governing Council members needs to be sufficient to attract and retain candidates with the level of skill and expertise appropriate to perform the important functions of the Councils. There also needs to be a balance between the appointment of Governing Council members with sufficient skills, expertise and local knowledge, and the potential for conflicts of interest to arise, particularly where Governing Council members are local clinicians/health professionals employed by that LHN.

3. Boundaries

The LHN boundaries need to facilitate and support consumer-friendly, accessible acute and primary health services, including transitions between acute and primary services. In particular, in Queensland these need to accommodate the diversity of health consumer populations and needs in rural and regional areas. Wherever possible common boundaries between LHNs and PHCOs should be established.

Common boundaries and/or partnerships should also be established between LHNs/PHCOs and other services with strong links to health, including aged care, HACC and disability services. Boundaries/partnerships between those services and government, community and social welfare agencies, such as those concerned with housing, drugs and alcohol, CALD communities and homelessness should also be developed to ensure collaboration and improved delivery of health care to marginalised Queenslanders. Understanding of social determinants of health and mechanisms to support whole of community planning are essential.

E. Key features of Primary Health Care Organisations

Functions/responsibilities

PHCOs will aim to ensure GP and primary health care is more integrated and responsive to local needs through:

1. improving local service delivery (ensuring less gaps in services);
2. working with local health professionals and engaging with the community to improve service collaboration and patient navigation of the local health system; and
3. working with LHNs to assist with hospital transitions and service coordination.

PHCOs responsibilities include:

- working with health care professionals to ensure cooperation/collaboration between services (to enable patients convenient/easy access);
- facilitation of allied health care/support for people with chronic illness;
- identifying groups missing out on primary health and GP care and services, and targeting services to respond;
- working '*with LHNs to identify the best pathways between services, and to assist with patients' transitions out of hospital, and where relevant into aged care'*;
- delivery of health promotion and preventative programs with the National Preventative Health Agency (once established); and
- population level planning.

Structure

- PHCOs will be independent entities (non-government organisations) with strong connections to local communities, health professionals and service providers.

- PHCOs will be locally governed, and will be comprised of members with broad community and health professional representation, and business and management expertise. There will be ‘strong clinical leadership’.

- There will be ‘common membership of governance structures’ with LHNs where possible.

- The Commonwealth and State Governments will collaborate to create linkages/coordination between PHCOs and other State services which relate to health, including mental illness, the homeless, and children at risk.

- The Commonwealth will determine the final number of PHCOs (ongoing consultation with the States regarding boundaries and structures of PHCOs will continue after boundaries are finalised).

- The States will not establish duplicate PHCO/GP organisations. Where such organisations already exist, they will become part of PHCO arrangements as ‘*coordinating entities for GP and primary health care services’*.

Role of the Commonwealth

The States/Territories have agreed to the transfer of policy and funding responsibility for General Practice and primary health care to the Commonwealth. Commonwealth responsibility for these services will take effect from 1 July 2011.

Primary health care services which will be transferred from the States to the Commonwealth include community health centre services; mental health care services for mild to moderate illnesses; non-acute care hospital avoidance programs; early intervention and prevention of chronic disease programs; screening programs for cancer; immunisation and any other services agreed between the Commonwealth and States.

The Commonwealth will also be responsible for Home and Community Care for people over 65 years (over 50 for Indigenous people) (**see Part F below**).

Role of the States

There will be ongoing collaboration between the States and the Commonwealth in relation to GP and primary health care policy (due to its impact on hospital services) and other planning matters.

The States will have responsibility for ongoing operation of services which receive Commonwealth funding.

Services excluded from transfer to the Commonwealth include ambulance services; existing public dental services; health care for prisoners; school and workplace primary care programs; hospital avoidance programs relating to patients predominantly being treated in acute care; and specialist STI and general sexual health services. Funding and policy responsibility for these services will be retained by the States.

The States are to consider, with a recommendation to be put to COAG in December 2010, the transfer of other services to the Commonwealth (or strong national reform in relation to those services). **Services to be considered for transfer** are community health promotion and population health programs including preventative health; drug and alcohol treatment services; child and maternal health services; and community palliative care.

Relationship between PHCOs and LHNs

- PHCOs/local LHNs will establish a formal engagement protocol.

- *'PHCOs will be the GP and primary health care partners of LHNs'*. Collaboration will occur around pathways between services, and transitioning patients from hospital (into aged care if appropriate).

- Common geographic boundaries 'wherever possible'.

Consumer engagement

The COAG agreement states that PHCOs will aim to improve delivery of GP and primary healthcare service more responsive to the needs of consumers by, among other things, '*working with local health care professionals and engaging with the community to ensure services work with each other so that patients will find it easier to navigate the local health system to find services they need'*.

Issues for HCQ

1. Role of consumers

Details of the mechanisms for consumer engagement with PHCOs, and the role of consumers are required.

As noted above in the issues regarding LHNs, health consumer representatives and community groups should be included in the governance of PHCOs to ensure consumer perspectives are provided and considered, and local community needs around primary health care service delivery and systems are met.

Again, a national consumer engagement framework should be implemented to guide PHCO engagement practises.

2. PHCOs

Details regarding the number of LHNs/ PHCOs Queensland will have and the number of LHNs each PHCO will support are required. If a Queensland PHCO is to have a formal engagement protocol with more than one LHN, additional resources, funding and support for that PHCO must be provided.

LHNs and PHCOs should have a key role in promoting consumer engagement and health literacy, and in delivering health programs.

3. Primary health care

Primary health care services must be integrated and delivered in a coordinated way. It is concerning that under the COAG agreement significant primary health care services including dental care and sexual health have been excluded from transfer to the Commonwealth. Consumers may find a split system confusing and difficult to navigate. Details regarding how the primary health care services to remain under State control will engage with Commonwealth primary health care services are required.

Seamless primary health care across all sectors is essential to obtain better health outcomes for consumers. Details as to how this will be delivered under the proposed model for LHN/PHCO collaboration are needed. Information is also required concerning

the mechanisms to be implemented to ensure seamless transitions between primary and acute care (and vice-versa).

Clarification of 'common membership of governance structures' for LHNs and PHCOs is required. Any common membership of governance structures should include consumers and community groups.

HCQ welcomes the intention to link health services and government, community and social welfare agencies, however further details regarding mechanisms for this are required. As noted above, there is a need for common boundaries between PHCOs/LHNs, aged care, HACC and disability services and government, community and social welfare agencies which interact with the health system (i.e. mental health, education, housing, income support), particularly for socially disadvantaged and vulnerable health groups with high support needs.

F. Aged Care, Home and Community Care and specialist disability services

***** It is noted that the State of Victoria has not agreed to the reforms detailed below.**

Key reforms

- SPP for jointly funded Home and Community Care (HACC) to end in 30 June 2011. Commonwealth to assume operational responsibility for HACC from 1 July 2012.

- From 1 July 2011 the Commonwealth will assume full funding and program responsibility for a national aged care system (excluding Victoria). It will be responsible for:

    1. Funding/regulation of basic community care services provided under the current HACC system for people over 65 (over 50 for Indigenous people).

    2. Funding specialist disability services provided under the National Disability Agreement for people over 65 (50 for Indigenous people).

    3. Funding packaged community and residential aged care under Commonwealth Aged Care Programs for people over 65 (as it does currently).

    4. Regulating packaged community and residential aged care under Commonwealth Aged Care Programs (as it does currently).

- From 1 July 2011 the States will be responsible for:

    1. Funding/programs for basic community care services delivered under the current HACC system for people under 65 (50 for Indigenous people).

    2. Funding packaged community and residential aged care services delivered through the Commonwealth aged care program to people under 65 (50 for Indigenous people).

    3. Regulating specialist disability services under the National Disability Agreement (as they do currently).

- The reforms are designed to '*enable the creation of a national aged care system and* national *disability services system',* and to integrate/ coordinate care systems to improve client services and accessibility/navigation of systems, and meet changing client needs.

- The Commonwealth will continue to assist in funding specialist disability services through the Disability Services Specific Purpose Payment. '*Current arrangements for access to disability services under the National Disability Agreement for people 65 and over (50 and over for Indigenous Australians) will remain unchanged'*.

- Program responsibility for community and residential care services for Indigenous people aged 50 – 64 years will be shared by the Commonwealth and States.

Issues for HCQ

The age divide of 65 (and 50 for Indigenous people) is arbitrary and is not individual-centred. It fails to take into account the vastly different care requirements of vulnerable individual consumers, regardless of their age. It may also result in people under 65 (or 50) and over 65 (or 50) failing to receive appropriate support services which meet their individual health and disability needs due to the arbitrary age divide.

It is hoped that the reforms to aged care, HACC and disability services will not result in people being displaced from their current living and social arrangements unless these individuals, their families and/or advocates/substitute decision-makers initiate, or are actively involved in any decisions around accommodation changes.

With a separation of funding and program responsibilities for HACC services for people under and over 65 (and 50 for Indigenous people) it is essential that a similar range of services to those currently funded and provided through the current HACC program be maintained to support these groups to continue to live within the community.

It is hoped that the reforms will result in better coordination and integration of aged care services. In implementing the reforms, it is imperative that individual funding packages for aged care, HACC and disability services are not compromised.

There needs to be alignment between the boundaries of LHNs and PHCOs with aged care services, HACC and DSQ services to ensure appropriate service delivery and transitions between services.

G. Performance and Accountability Framework

A Performance and Accountability Framework will be established, comprising features including:

- National performance indicators;

- National clinical and quality safety standards;

- Hospital Performance Reports and Healthy Community Reports concerning the performance of LHNs, hospitals and PHCOs.

COAG will initially develop National Standards regarding emergency departments and elective surgery.

H. National Governance

National governance functions will be introduced and commence on 1 July 2011, including:

1. An **Independent Hospital Pricing Authority**: it will establish the pricing for the Commonwealth's contributions to hospitals, and determine block funding payments.

At least one member of the authority (to be comprised of five members, a Deputy Chairperson and a Chairperson appointed by COAG) will have regional and rural expertise.

2. An **independent National Performance Authority** (NPA): it will be responsible for performance monitoring and reporting on each LHN; the hospitals within each LHN; every private hospital and every PHCO. At least one member of the authority will have regional and rural expertise.

   Reporting will occur through transparent **quarterly Hospital Performance Reports and Healthy Communities Reports** produced by the NPA. Reports will be initially developed by COAG and reviewed by Health Ministers thereafter, and will include service and financial performance standards; National Standards; and some clinical quality and safety measures developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC). **Monitoring of the National Standards** will be by the NPA at the local level, and the COAG Reform Council at the State/national level.

3. The establishment of national clinical quality and safety standards by the ACSQHC.

4. Regular public reporting of each State/Territories' performance against the performance indicators, new National Standards, and new national clinical quality and safety standards; and independent performance assessment by the COAG Reform Council.

<u>Issue for HCQ</u>

1. Role of consumers

Consumers must be involved and represented in the development of National Standards and clinical standards. Broad community consultation in relation to proposed National Standards should occur.

Consumers should be represented in the governance structure of the National Performance Authority, and involved in the LHN/PHCO performance monitoring process.

2. State issues

The governance bodies proposed under the agreement appear to be overarching national bodies. Mechanisms are required to ensure local and State-specific systemic issues are identified and addressed. This could occur through the establishment/maintenance of a body/organisation at the State level to address local and State systemic issues, for example, in relation to quality and safety.

3. Complaints and monitoring

Details are needed about processes and mechanisms for consumer complaints about hospitals and LHNs, including the appropriate body to which complaints can be made. Information is also required about investigation processes, including who will be responsible for investigations, and whether investigations will take place at the State or Federal level.

I. Other reforms of interest to Queensland health consumers

- **Mental illness:** Consideration is to be given the transfer of responsibility to the Commonwealth for specialist community mental health services for people with severe mental illness (with a report to be provided to COAG in 2011).

- **Patient assisted travel scheme:** The Commonwealth and States have agreed to undertake further work in relation to this, with a view to developing higher, more consistent national standards.

- **Four hour National Access Target for emergency departments:** The Commonwealth and States have agreed to the staged implementation of a four hour National Access Target for emergency department treatment. Admission, referral or discharge will occur within four hours of arrival, where clinically appropriate.

Issues for HCQ

There is no detailed discussion in the agreement in relation to the dental health reform agenda. It appears that the States will retain responsibility for dental health. This was a significant aspect of the Commonwealth's health reform agenda in June 2009. Details of the reforms which are intended for dental health, and how dental health will fit into the LHN and PHCO structure are sought.

There is a need for a consistent and equitable approach to guidelines and funding for the Patient Assisted Travel Scheme.

In implementing a four hour National Access Target for emergency departments, it is vital that the quality and safety of care received by patients is not compromised to ensure compliance with the target. The focus must remain on delivering a high standard of care to the consumer.

Key areas requiring more detail and clarity around future policy, program and service delivery include: Dental care; mental health (acute); Indigenous health; rural/regional issues; the Medical Aids Assistance Scheme; preventative health; E-health (discussions are to commence in coming months to move towards implementation of the National Individual Electronic Health Record System); health literacy; women's health and CALD communities' health.

Further issue for HCQ

The Health System principles agreed by COAG in November 2008 include that Australia's health system should 'be shaped around the health needs of individual patients, their families and communities'.

The structural reforms to the health system are 'top heavy' and appear to impose further layers of bureaucracy and administration, rather than facilitating local control and meeting local communities' health care needs. Health consumers and their representatives must have an ongoing role in the management of their health care and the decisions being made which influence the health and wellbeing of their communities.

The absence of consumer engagement frameworks and mechanisms in the COAG agreement is also concerning. There is a need for strategies to be included which empower consumer, facilitate their involvement in health policy and systemic reform initiatives and formally recognise the value of consumer engagement.