

Senate Finance and Public Administration Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals  
7 June 2010

Question no: 01 & 02

OUTCOME 0: Whole of Portfolio

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

1. Within the \$5.4 billion Commonwealth funding what measures are new spending? Please including the inputs, assumptions and modelling underpinning these funding amounts?
2. Within the \$5.4 billion Commonwealth funding what is re-directed from existing programs and or areas? What is the impact on these existing programs?

Answer:

Attachment A sets out the \$9.1 billion total funding for the National Health and Hospitals Network. The total funding comprises \$7.3 billion in new funding, the balance being redirected funding. Within the \$7.3 billion new funding, \$5.4 billion (\$5.1 billion new funding) was announced at the Council of Australian Governments' meeting of 19-20 April 2010. The remaining funding was announced in the 2010-11 Budget.

Theme/Measure Title	New funding (\$m)	Redirected funding (\$m)	Major assumptions underpinning new funding	Impact of redirected funding on existing programs
<b>COAG ANNOUNCEMENTS</b>				
<b>HOSPITALS</b>				
Four hour national access target for emergency departments – facilitation and reward	501.9	-	<ul style="list-style-type: none"> <li>Estimated 805,000 emergency department attendances in 2013-14, based on the marginal cost of delivering services agreed with the states and territories.</li> <li>Funding will be initially distributed amongst the 165 hospitals that already report on patient level ED data.</li> </ul>	N/A
Four hour national access targets for emergency departments – capital funding	251.4	-	<ul style="list-style-type: none"> <li>All states and territories will be provided with a minimum of \$5 million over four years.</li> <li>Funding will be initially distributed amongst the 165 hospitals that already report on patient level ED data.</li> </ul>	N/A
Improving access to elective surgery – facilitation and reward funding	652.3	-	<ul style="list-style-type: none"> <li>22,000 additional elective surgery procedures in 2013-14 based on the marginal cost of delivering services agreed with the states and territories.</li> </ul>	N/A
Improving access to elective surgery – capital funding	150.7	-	<ul style="list-style-type: none"> <li>The equivalent of 15 new operating theatres or seven day surgery centres nationwide.</li> </ul>	N/A
New sub-acute hospital beds	1,625.4	-	<p>Commonwealth will fully fund the capital and recurrent costs of 1,316 new subacute care beds by 2013-14.</p> <p>Capital funding:</p> <ul style="list-style-type: none"> <li>\$600,000 per bed in 2010-11, with application of the Health Cost Index (3.8%) for subsequent years</li> </ul> <p>Recurrent funding:</p> <ul style="list-style-type: none"> <li>\$220,000 in 2010-11, with application of the Health Cost Index (3.8%) for subsequent years.</li> </ul>	N/A

Flexible funding for emergency departments, elective surgery and sub-acute care	200.4	-	<p>\$200 million investment could support the equivalent of either:</p> <ul style="list-style-type: none"> <li>• 325,000 emergency department attendances per annum;</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>• 13,700 additional elective surgery procedures per annum;</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>• 300 additional sub-acute beds.</li> </ul>	N/A
<b>GENERAL PRACTICE AND PRIMARY CARE</b>				
Coordinated diabetes care	449.2	352.2	<ul style="list-style-type: none"> <li>• 260,000 patients with diabetes will be enrolled with their general practice by 2013-14.</li> </ul>	<ul style="list-style-type: none"> <li>• Expenditure on GP and allied health MBS services (Program 3.1 Medicare Services) that enrolled patients with diabetes would have otherwise accessed will be redirected to this measure. This expenditure is based on average MBS service levels for patients with diabetes for general care, and MBS rebates for chronic disease management and allied health services (including associated bulk billing incentives). There is a small saving (\$9.3 million) related to abolishing the PIP Diabetes Incentive (Program 5.4 Practice Incentive Program).</li> </ul>
<b>WORKFORCE</b>				
More places on General Practice Training Program	344.9	-	<ul style="list-style-type: none"> <li>• 1,360 GP training places over 4 years @ \$60,000 each for training costs.</li> <li>• 680 rural GP training places over 4 years @ \$28,063 each for rural incentives.</li> <li>• Includes flow on costs for MBS, PBS and PIP.</li> <li>• Also includes Medicare Australia and Department of Veterans Affairs costs.</li> </ul>	N/A
More general practice training rotations for junior doctors	149.6	-	<ul style="list-style-type: none"> <li>• 1,950 placements over 4 years @ an average of \$54,570 per place (including administration costs).</li> <li>• Includes Departmental costs as well as flow on costs for MBS and PBS.</li> <li>• Also includes Medicare Australia and Department of Veterans Affairs costs.</li> </ul>	N/A

Training specialist doctors	144.5	-	<ul style="list-style-type: none"> <li>• 800 new places over 4 years @ \$130,000 per place.</li> <li>• 1,779 existing places over 4 years @ \$20,000 per place.</li> <li>• Includes Departmental costs.</li> </ul>	N/A
Expanding clinical placement scholarships for allied health students	6.5	-	<ul style="list-style-type: none"> <li>• 400 scholarships over 4 years costed at up to \$11,000 per scholarship.</li> <li>• Includes Departmental and administration costs.</li> </ul>	N/A
Rural locum scheme for allied health professionals	5.3	-	<ul style="list-style-type: none"> <li>• 400 locums over 4 years @ \$8,280 per locum.</li> <li>• Includes Departmental and administration costs.</li> </ul>	N/A
<b>AGED CARE</b>				
Expand access to multi-purpose services	122.0	-	<ul style="list-style-type: none"> <li>• 286 beds over 3 years @ \$406,000 per bed (2010-11 dollars).</li> </ul>	N/A
Supporting long stay older patients (Financial assistance component)	2.7	276.4	<ul style="list-style-type: none"> <li>• 5,100 aged care places over 3 years @ \$53,000 per place (2011-12 dollars).</li> </ul>	Funding will temporarily be redirected from the residential care program to support long stay older patients in hospitals.
Reform of roles and responsibilities – Home and Community Care and related programs	38.3	-	<ul style="list-style-type: none"> <li>• Departmental costs plus funding to states and territories plus capital costs (details are commercial-in-confidence)</li> </ul>	N/A
One stop shops	36.8	-	<ul style="list-style-type: none"> <li>• Departmental costs plus capital costs plus funding for assessments (details are commercial-in-confidence)</li> </ul>	N/A
Expansion of zero real interest loans	145.0	-	<ul style="list-style-type: none"> <li>• Loans are treated as financial assets and therefore only the concessional interest cost of offering the loan impacts on the fiscal balance. The interest revenue foregone is an upfront cost to the Budget in the years that the funds are lent out, amortised over the life of the loan</li> </ul>	N/A
Improving access to General Practice and primary health care	98.6	14.1	<ul style="list-style-type: none"> <li>• Up to 1,200 additional GPs are expected to be receiving incentive payments by 2013-14.</li> <li>• 105,000 additional GP services being provided to older Australians in aged care homes in the four years to 2013-14.</li> <li>• An additional 190,000 primary health care services will also be provided to older Australians in 2012-13 and to 2013-14.</li> </ul>	<ul style="list-style-type: none"> <li>• Funding for additional primary health care services in the two years to 2013-14 will include redirected funding of \$14.1 million from the allied health component of the current Aged Care Access Initiative (Program 5.2 Primary Care Financing), resulting in termination of this component of the initiative.</li> </ul>
Improving the viability of community care providers	10.1	-	<ul style="list-style-type: none"> <li>• Current average viability supplement payment multiplied by 141%.</li> </ul>	N/A

Strengthening arrangements for complaints	50.6	-	<ul style="list-style-type: none"> <li>Departmental costs plus additional funding for Aged Care Standards and Accreditation Agency.</li> </ul>	N/A
Protecting savings	21.8	-	<ul style="list-style-type: none"> <li>Departmental costs plus external advice plus capital.</li> </ul>	N/A
<b>MENTAL HEALTH</b>				
More youth friendly services	78.8	-	<ul style="list-style-type: none"> <li>Up to 30 new headspace sites, and additional funding for existing headspace sites.</li> <li>Includes Departmental and administration costs.</li> </ul>	N/A
Expanding the Early Psychosis Prevention and Intervention Centre model	25.5	-	<ul style="list-style-type: none"> <li>Up to 3,500 young people aged 16 to 25 and their families will benefit.</li> <li>Four sites expected, with cost-sharing between Commonwealth and interested State and Territory Governments.</li> <li>Includes Departmental and administration costs.</li> <li>136 mental health nurses providing 11,700 services over 2 years.</li> </ul>	N/A
Additional mental health nurses	13.0	-		N/A
Flexible care packages for people with severe mental illnesses	5.9	52.6	<ul style="list-style-type: none"> <li>Up to 25,000 flexible care packages.</li> <li>Includes Departmental and administration costs.</li> </ul>	Funding will be redirected from the Better Access to Psychiatrists, Psychologists and GPs through the MBS program from 1 April 2011 to provide new flexible care packages to better care for people diagnosed with severe mental illness in the community. The Better Access program is demand driven; to date 95% of all services have been delivered by psychologists. From 1 April 2011 social workers and occupational therapists will no longer be able to provide Medicare rebateable services to new clients under Better Access. However, occupational therapists, social workers and mental health nurses will be among the key providers of the new care packages. Transitional arrangements from 1 April 2011 will enable existing Better Access patients of social workers and occupational therapists to complete a course of treatment they have commenced with one of these providers, up to 30 September 2011.
<b>COAG ANNOUNCEMENTS</b>	<b>5,131.1</b>	<b>695.2</b>		
<b>SUB-TOTAL</b>		<b>\$5.8 billion*</b>		

POST-COAG ANNOUNCEMENTS			
HOSPITALS			
Activity based funding	163.4	-	<ul style="list-style-type: none"> <li>Funding over four years to develop the Information and Communication Technology (ICT) infrastructure needed to support activity based funding and calculate the Commonwealth's financial contribution to public hospital services.</li> </ul>
<b>GENERAL PRACTICE AND PRIMARY CARE</b>			
Improved primary care infrastructure	355.2	-	<p><b>GP Super Clinic Grants</b></p> <ul style="list-style-type: none"> <li>Around 23 organisations will be funded to build new GP Super Clinics: <ul style="list-style-type: none"> <li>Approximately nine new large GP Super Clinics, with funding of up to \$15 million for each clinic.</li> <li>Approximately 14 new medium GP Super Clinics, with funding of up to \$7 million for each clinic, will also provide access to a wide range of health professionals and services, scaled to suit a smaller population than the large clinics.</li> </ul> </li> </ul> <p><b>Grant upgrades</b></p> <ul style="list-style-type: none"> <li>Upgrades to 425 existing Primary health care facilities, community health services, and Aboriginal Medical Services to deliver team based care and GP Super Clinic style services: <ul style="list-style-type: none"> <li>Grants of up to \$150,000 will be available to existing general practices, primary care and community health services, and Aboriginal Medical Services to expand or upgrade, for example, allied health services or provide accommodation for an additional GP or practice nurse.</li> <li>Grants of up to \$300,000 will be available to existing facilities that, for example, expand or upgrade accommodation for additional doctors, allied health professionals or practice nurses, strengthen team based care services</li> </ul> </li> </ul>
			N/A

			<ul style="list-style-type: none"> <li>and offer extended hours.</li> <li>Grants of up to \$500,000 will be available for existing facilities that, in addition to the previously identified elements, also establish teaching facilities and transition to a GP Super Clinic style facility.</li> </ul>	
Establishing Medicare Locals and improving access to after hours primary care	416.8	307.2	<p><b>Medicare Locals</b></p> <ul style="list-style-type: none"> <li>\$290 million to establish a national network of primary health care organisations known as 'Medicare Locals'.</li> <li>The number of Medicare Locals to be established will be determined following consultations with stakeholders (to be agreed between the Commonwealth and states by 31 December 2010).</li> </ul> <p><b>Improving Access to After hours primary Care</b></p> <ul style="list-style-type: none"> <li>\$118.6 million to establish a free, telephone-based GP medical advice service available to all Australians, as an add-on service to the nurse triage, information and advice services currently provided by the National Health Call Centre Network.</li> <li>\$127 million for the provision across Australia of local face-to-face after hours primary care services throughout Australia via Medicare Locals progressively commencing from 2013-14.</li> </ul>	<p><b>Medicare Locals</b></p> <ul style="list-style-type: none"> <li>Includes re-directed funding of \$186.5 million from the Divisions of General Practice Program.</li> </ul> <p><b>Improving Access to After hours primary Care</b> This program includes redirected funding from:</p> <ul style="list-style-type: none"> <li>Practice Incentives Program (PIP) of \$106.2 million (PIP Tiers 1, 2 and 3 will be phased out by July 2013).</li> <li>General Practice After Hours Program of \$14.5 million.</li> </ul>
Improving access to primary care	NFP	NFP	NFP	N/A
<b>WORKFORCE</b>				
Rural locum scheme for nurses	28.8	-	<ul style="list-style-type: none"> <li>3,000 locums @ \$8,280 per locum over 4 years.</li> <li>Includes Departmental, administration, development and overhead costs.</li> </ul>	N/A
Nurse practitioners	18.7	-	<ul style="list-style-type: none"> <li>Number of trials multiplied by cost per trial.</li> </ul>	N/A
Exploring regulation of the personal care workforce	3.5	-	<ul style="list-style-type: none"> <li>National scope of practice and competency framework.</li> <li>Mapping project on existing vocational training sector qualifications to the competency</li> </ul>	N/A

				framework. <ul style="list-style-type: none"> <li>Includes Departmental costs.</li> </ul>	
Training and education incentive payments	59.9	-	-	<ul style="list-style-type: none"> <li>Number of payments multiplied by average cost per payment.</li> </ul>	N/A
Building nursing careers	21.0	-	-	<ul style="list-style-type: none"> <li>Number of scholarships multiplied by cost per scholarship</li> </ul>	N/A
Supporting a professional aged care workforce	-	211.2	-	<ul style="list-style-type: none"> <li>Continuation of previous programs plus new clinical training places, graduate placements and teaching nursing homes.</li> </ul>	Funding is being redirected in this budget to new measures aimed at ensuring the retention of the existing nursing workforce and increased recruitment.
Research into aged care staffing levels	0.5	-	-	<ul style="list-style-type: none"> <li>Estimated cost of research.</li> </ul>	N/A
Support for practice nurses	390.3	437.0	-	<ul style="list-style-type: none"> <li>The practice nurses program will provide incentives of \$25,000 per full time GP for a Registered Nurse and \$12,500 per full time GP for an Enrolled Nurse.</li> <li>By the end of 2013-14 this program will support 4,400 practices in employing 4,593 practice nurse FTE positions.</li> </ul>	<ul style="list-style-type: none"> <li>Redirected funding to the Practice Nurse measure is \$437 million this comprises: <ul style="list-style-type: none"> <li>\$139.8 million from PIP Practice Nurse; and</li> <li>\$297.2 million from Practice Nurse MBS items that will be discontinued.</li> </ul> </li> </ul>
<b>AGED CARE</b>					
Supporting long stay older patients (Continuation of the LSOP initiative for two years only component)	0	75.0	-	<ul style="list-style-type: none"> <li>\$37.5 million per year split between states and territories on an age-weighted population basis, with a floor level of \$300,000 for the territories.</li> </ul>	Funding for 2010-11 and 2011-12 was provided for this program in the forward estimates.
Increasing business efficiency	7.0	-	-	<ul style="list-style-type: none"> <li>Cost of data collection plus cost of advisory service.</li> </ul>	N/A
<b>PREVENTION</b>					
Plain packaging of tobacco products	2.6	-	-	<ul style="list-style-type: none"> <li>Legislation for plain packaging of tobacco products will commence 1 January 2012.</li> <li>Includes Departmental and legal costs.</li> </ul>	N/A
National tobacco campaign – more targeted approach	-	27.8	-	<ul style="list-style-type: none"> <li>Retargeting of existing funding.</li> </ul>	Funding from the lapsing National Tobacco Youth Campaign is being rebudgeted and refocused to target and reduce the high smoking prevalence rates among people in high-need and highly disadvantaged groups who are hard to reach through mainstream anti-smoking campaigns.
<b>eHEALTH</b>					
Personally controlled electronic health records	466.7	-	-	<ul style="list-style-type: none"> <li>\$466.7 million to establish a personally controlled electronic health record system.</li> <li>From July 2012, all Australians who choose to have one, will be able to register online for a personally controlled electronic health record.</li> </ul>	N/A



<b>GOVERNANCE</b>						
Independent Hospital Pricing Authority	91.8	-	<ul style="list-style-type: none"> <li>Staffing, classification and cost refinement and maintenance, developing and maintaining National Cost Standards and Minimum Data Sets.</li> </ul>		N/A	
National Performance Authority	109.5	9.1	<ul style="list-style-type: none"> <li>Staffing, clinical registries, performance maintenance and reporting.</li> </ul>		The 9.1 million is being redirected from the Hospital Accountability and Performance Program. There will be minimal impact on the Hospital Accountability and Performance Program as the redirection of funding relates to functions that will continue in the National Performance Authority.	
Expansion of the Australian Commission on Safety and Quality in Health Care	35.2	-	<ul style="list-style-type: none"> <li>Funding contingent on States and Territories contributing \$48 million over 3 years, 2011-2014, consisting of existing funding commitments (\$16.5 million) plus increased contributions (\$31.5 million).</li> </ul>		N/A	
Rebalancing financial responsibility in the federation	-	-	<ul style="list-style-type: none"> <li>Estimated costs of younger people in aged care services and of older people in state and territory government services.</li> </ul>		N/A	
<b>BUILDING THE FOUNDATIONS FOR REFORM</b>						
Information and awareness	29.5#	-	<ul style="list-style-type: none"> <li>National media buy \$19.8 million over 4 years</li> <li>Research, Creative agency fees, CALD &amp; Indigenous specific, Public Relations activities, Website development and maintenance, Printing, Distribution, Mailing costs for information materials and resources \$7.54 million over 4 years</li> <li>Departmental \$2.12 million over 4 years</li> </ul>		N/A	
<b>POST-COAG ANNOUNCEMENTS</b>	<b>2,200.5</b>	<b>1,067.3</b>				
<b>SUB-TOTAL</b>		<b>\$3.3 billion</b>				
<b>TOTAL</b>	<b>7,331.5</b>	<b>1,762.5</b>				
		<b>\$9.1 billion</b>				

\*The gross cost of \$5.8 billion includes departmental and administered costs for the Department of Health and Ageing (DHA) and other agency costs, whereas the \$5.4 billion announced at COAG only includes administered and some departmental costs for DHA.

#2009-10 funding, totaling \$9.9 million, will be sourced from underspends within the relevant outcomes. An Advance to the Finance Minister will be sought if the relevant appropriation is fully spent.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals  
7 June 2010

Question no: 03

OUTCOME 0: Whole of Portfolio

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

What are the projected savings in existing health programs across the forward estimates from these new financial arrangements, please including the inputs, assumptions and modelling underpinning these funding amounts?

Answer:

Significant projected savings in existing health programs across the forward estimates relate to the Pharmaceutical Benefits Scheme (PBS). In particular:

- 1) Savings of \$1.3 billion over the forward estimates (\$1.9 billion over 5 years) will be achieved through further pricing reform. Immediate savings will be achieved through statutory price reductions, and longer term savings will be achieved by expanding price disclosure arrangements. These reforms are supported by Medicines Australia.
- 2) The Fifth Community Pharmacy Agreement will result in gross savings of \$1 billion over the life of the Agreement and net savings of \$600 million (net savings of \$483.5 million over the forward estimates).

Details of other savings in existing health programs across the forward estimates are provided in the 2010-11 Budget Paper No. 2.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals  
7 June 2010

Question no: 04

OUTCOME 0: Whole of Portfolio

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

What is the projected number of additional and new services this additional funding will provide:

- in elective surgery treatments;
- in emergency department treatments;
- in expected numbers of patients to sign up to the diabetes spending measure; and
- number or general practitioner (GP) treatments in aged care facilities.

Please provide the inputs, assumptions and modelling underpinning these projections for all the above measures.

Answer:

*Elective Surgery - \$650 million over four years in recurrent funding*

By 2013-14, new funding will provide for 22,000 additional elective surgery procedures in that year, based on the marginal cost of delivering services agreed with the states and territories.

Additionally, \$150 million over four years is being provided in capital funding, which will support the delivery of these services.

*Emergency Departments - \$500 million over four years in recurrent funding*

This will provide for the equivalent of an estimated 805,000 emergency department attendances in 2013-14, based on the marginal cost of delivering services agreed with the states and territories.

Additionally, \$250 million over four years is being provided in capital funding, which will support the delivery of these services.

*Sub-acute Care - \$1.6 billion over four years in capital and recurrent funding*

This will fund the creation of 1,316 additional beds in the public hospital system by 2013-14. Subsequent to the COAG Agreement, it has been estimated that based on an average length of stay for sub-acute care of 19.29 days (AIHW Australian Hospital Statistics, 2007-08, tables 7.11 and 7.12), this will support the delivery of an estimated 24,900 services over the

next four years, and on an ongoing basis once all the new beds are operational. It will also free up an equivalent number of beds in public hospitals.

*Sub-acute Care - \$122.0 million over four years in capital funding*

This will fund the creation of 286 sub-acute beds, or their equivalents, in new and existing Multi-Purpose Services. Subsequent to the COAG Agreement, it has been estimated that based on an average length of stay for sub-acute care of 19.29 days (AIHW Australian Hospital Statistics, 2007-08, tables 7.11 and 7.12), this will support up to 5,400 services a year and will increase the availability of more appropriate care options for long stay older patients in rural and remote areas.

*Flexible Funding (\$200 million) – to be directed at Emergency Departments, Elective Surgery or Sub-Acute Care*

The distribution of these funds will be agreed between the Commonwealth and each state. This will support the equivalent of either:

- 325,000 emergency department attendances per annum, based on the marginal cost of delivering services agreed with states and territories;  
OR
- 13,700 additional elective surgery procedures per annum, based on the marginal cost of delivering services agreed with the states and territories;  
OR
- 300 additional sub-acute beds. Subsequent to the COAG Agreement, it has been estimated that this will support the delivery of an estimated 5,700 services per annum (based on an average length of stay for sub-acute care of 19.29 days).

Further details are available from pages 92 to 99 of ‘*A National Health and Hospitals Network for Australia’s Future: Delivering Better Health and Better Hospitals*’.

*Coordinated Care for Patients with Diabetes - \$449.2 million over four years*

This measure will enable the flexible delivery of coordinated primary health care services through general practice for the treatment and ongoing management of people with diabetes who voluntarily enrol with their general practice.

Over 4,300 accredited general practices, covering around 60 per cent of all general practices, are expected to sign-on to the program in its first year of operation (2012-13). It is expected that approximately 260,000 patients with diabetes will be enrolled with their general practice by 2013-14.

Further details are available from pages 65-66 of ‘*A National Health and Hospitals Network for Australia’s Future: Delivering Better Health and Better Hospitals*’.

*Aged Care*

This measure will provide:

- increased financial initiatives to GPs to provide more services to older Australians in aged care homes; and
- flexible funding to target gaps in primary health care for older Australians.

From 1 July 2010 incentive payments will increase from \$1000 to \$1500 a year for GPs who provide at least 60 attendances to older people in aged care homes and from \$1500 to \$3500 a year for GPs who provide at least 140 attendances to older people in aged care homes.

The increased financial incentives through the Aged Care Access Initiative (ACAI) are expected to support around 105,000 additional GP services being provided to older

Australians in aged care homes in the four years to 2013-14.

Under this measure, the Government will also set up a flexible funding pool from 2012-13, to be administered by Medicare Locals and to target gaps in primary health care services for aged care recipients. This is expected to result in an additional 190,000 primary health care services in the two years to 2013-14.

Further details are available from pages 115 to 123 of '*A National Health and Hospitals Network for Australia's Future: Delivering Better Health and Better Hospitals*'.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals  
7 June 2010

Question no: 05

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

Within the \$15.6 billion top-up payments guaranteed to the states by the Commonwealth in the period 2014-15 to 2019-20, please provide the breakdown of expenditure relating to:

- hospitals;
- outpatient services;
- capital expenditure;
- GP and primary healthcare;
- aged care; and
- other areas of health expenditure.

Answer:

The Commonwealth Government has guaranteed a top-up payment to states and territories of no less than \$15.6 billion between 2014-15 and 2019-20. This amount represents the Commonwealth's estimate of the additional share of growth the Commonwealth will be taking on by virtue of becoming the dominant funder of the health and hospital system.

The Commonwealth's guarantee has been specified at the aggregate level and is in place to ensure that across the various elements of the National Health and Hospitals Network policy, states and territories received a guaranteed minimum total additional funding contribution from the Commonwealth.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals  
7 June 2010

Question no: 06

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

Within the National Health and Hospitals Network please provide the names, roles, structures, operations, resourcing, funding and staffing of any new statutory bodies, organisations or other entities needed to establish, oversee, monitor, report upon or administer the National Health and Hospital Networks, Primary Care Organisations and the funding channels to be established under the COAG agreements?

Answer:

New governance arrangements will be established to support the effective functioning of the National Health and Hospitals Network. These institutions will fulfil three roles: planning and managing the delivery of services to suit local needs; national institutions to develop and oversee national standards and performance; and national institutions overseeing the new funding arrangements.

*New institutions delivering tailored services in local communities*

Governance and management of local health and hospital services will be devolved to the local level. To support this, new local governance institutions will be established, ensuring that health and hospital services meet local needs and circumstances: Local Hospital Networks and Medicare Locals. To formally enhance cooperation between hospital and primary care services in a community, Medicare Locals will be expected to have some common membership of governance structures with Local Hospital Networks, and vice versa. In addition, Medicare Local funding agreements will require them to work closely with Local Hospital Networks, and vice versa.

Local Hospital Networks

Local Hospital Networks will be responsible for managing and delivering hospital services, including day to day operations. They will be established as separate legal entities under state or territory legislation, in line with nationally agreed characteristics and in close consultation with the Commonwealth. The Commonwealth and states and territories will work together to ensure, wherever possible, common geographic boundaries with Medicare Locals (details below).

Medicare Locals

Medicare Locals will be independent legal entities, working with local GPs and Local Hospital Networks to improve patient care and quality and safety of health services. The first Medicare Locals will commence operations in mid-2011, with the remainder commencing operations in mid-2012. The Commonwealth and states and territories will work together to ensure, wherever

possible, common geographic boundaries with Local Hospital Networks (details above). The Government is providing \$416.8 million over four years to establish a national network of Medicare Locals and to improve access to after hours primary care services.

#### *Ensuring national standards and accountability*

The National Health and Hospitals Network will be underpinned by strong national standards and transparent reporting. Two new independent authorities will be established by the Commonwealth to develop and oversee these national standards: the Australian Commission on Safety and Quality in Health Care and the National Performance Authority.

#### Australian Commission on Safety and Quality in Health Care

The Australian Commission on Safety and Quality in Health Care (the Commission) will have an expanded role that will see it developing national clinical safety and quality standards for clinical best practice and enhanced safety in the health system. This will include developing clinical guidelines for the treatment of key diseases and conditions and standards of clinical care. Clinical guidelines and standards will, over time, be implemented across all sectors of the health system. The Commonwealth Government has made an additional \$35.2 million available over four years for the Commission to perform its functions.

#### National Performance Authority

In undertaking its work, the National Performance Authority will provide comparative analysis across jurisdictions, identify best practice, and focus on the achievement of results. The National Performance Authority is to provide clear and transparent public reporting of the performance of every Local Hospital Network, the hospitals within it, every private hospital and every Medicare Local, through the new Hospital Performance Reports and Healthy Communities Reports. The Commonwealth is making available \$118.6 million over four years to meet the costs of the Authority.

#### *Ensuring transparent funding arrangements*

The National Health and Hospitals Network will see, for the first time, Commonwealth and state and territory funding for public hospitals clearly identified and clearly linked to actual services delivered to patients. The Independent Hospital Pricing Authority and National Health and Hospitals Network Funding Authorities in each state and territory are being established to oversee these funding arrangements.

#### Independent Hospital Pricing Authority

The Independent Hospital Pricing Authority will: calculate and determine the national efficient price, state-specific prices, and the relevant cost weights to be applied to Commonwealth payments for admitted patient, emergency department, sub-acute and outpatient services in line with the provisions contained in Appendix 2 of the National Health and Hospitals Network Agreement; and maintain, update and determine the national activity based funding classifications and costing models. The Commonwealth is providing \$91.8 million over four years to meet the costs of the Authority.

#### National Health and Hospitals Network Funding Authorities

National Health and Hospitals Funding Authorities will be established in each state and territory and will: be jointly governed by the Commonwealth and the state; transparently report on the number of services provided and paid for; receive clearly identified Commonwealth and state funds, with Commonwealth funds flowing on directly to Local Hospital Networks based on services provided; have no policy or operational role, beyond receiving activity-based payments from the Commonwealth and state/territory and making payments directly to Local Hospital Networks.



Senate Finance and Public Administration Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals  
7 June 2010

Question no: 07

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

What arrangements are in place, or are being negotiated for states that have not signed up, nor fully signed up to the COAG agreements, including what contingencies have been put in place for states that may want to alter agreements in future?

Answer:

I refer you to the response the Department of the Prime Minister and Cabinet have provided.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals  
7 June 2010

Question no: 08

OUTCOME 13

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

Who will have final approval of the number and size of Local Hospital Networks in each state and territory?

Answer:

Paragraph A7 of the NHHN Agreement provides, *inter alia*, that:

In establishing LHNs: States will work cooperatively with the Commonwealth to ensure, wherever possible, common geographic boundaries with PHCO boundaries as outlined under provision B24;

And also that:

...as a transitional matter to establish the new system, the boundaries will be initially resolved bilaterally between First Ministers by 31 December 2010;

Similarly, paragraphs B24 and B25 of the NHHN Agreement provide, *inter alia*, that:

In establishing [Medicare Locals], the Commonwealth will work cooperatively with States to ensure, wherever possible, common geographic boundaries with LHNs as outlined in provision A7.

And also that:

...as a transitional matter to establish the new system, the boundaries will be initially resolved bilaterally between First Ministers by 31 December 2010.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals  
7 June 2010

Question no: 09

OUTCOME 13

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

Please provide the number of hospitals which will receive: activity-based funding, block grant funding, or a mix of both?

Answer:

In accordance with the National Health and Hospitals Network Agreement, the Independent Hospital Pricing Authority will provide advice to COAG on the definition and typology of public hospitals eligible for:

- i. block funding only;
- ii. mixed ABF and block funding; and
- iii. ABF only.

Based on that advice, COAG will determine the number of hospitals that will receive activity-based funding, block grant funding, or a mix of both.

Senate Finance and Public Administration Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Inquiry into COAG reforms relating to health and hospitals  
7 June 2010

Question no: 10

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

Did the State and Territories request that clinicians not be included specifically in the wording of the agreement in relation to governing councils and Local Hospital Networks?

Answer:

I refer you to the response the Department of the Prime Minister and Cabinet have provided.