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Issues Paper

National Health Reform Response

Australian Healthcare & Hospitals Association

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1. INTRODUCTION

1.1 AHHA role

The Australian Healthcare and Hospitals Association (AHHA) is the independent peak membership body and advocate for the Australian public healthcare system. The Association is the voice of public healthcare.

1.2 Guiding principles for reform

The AHHA offers seven Guiding Principles to govern development, implementation and evaluation of the National Health Reforms:

1. Clear political accountability to the community for funding and health outcomes including sufficient funding for areas and populations of need;
2. Clear provider accountability to funders and consumers for efficiency and health outcomes, including safety and quality;
3. Integrated planning and coordinated delivery of care within and across jurisdictions, healthcare settings and professional groups;
4. Use of incentives to ensure the most appropriate care setting with the providers best suited to treat each unique patient;
5. Use of appropriate data and analysis to inform healthcare planning and delivery and to provide the basis for transparent public reporting;
6. Consumer and community involvement as active and informed participants in healthcare planning and delivery; and
7. Workforce education and training informed by best models of care and partnerships between researchers, employers and educators.

1.3 The National Health Reforms (NHR)

The AHHA views the NHR as a timely opportunity to address these guiding principles.

The Association has grouped the Reform agenda into three 'headline' areas: transparency of, and accountability for, funding; local governance; and nationally consistent performance standards and reporting.

This paper will discuss issues arising from each of these areas from the perspective of AHHA members. Section 2 provides Key Messages and a more detailed response is discussed in Sections 3 - 6 [1].

[1] For reference, the Heads of Agreement (COAG meeting on 13/2/11) is at attachment #1). For a short background to the health reforms, see Appendix #1

2. NATIONAL HEALTH REFORM - KEY MESSAGES

2.1 Transparency of, and accountability for, funding

The Association believes the reforms provide a new framework for improved transparency of, and accountability for, the shared funding arrangements between the Commonwealth and state/territory governments, particularly in relation to public hospitals. This has the potential to minimise cost and blame shifting and will be achieved through:

- confirmation of the role of states/territories as 'system managers', recognising the traditional expertise of the states/territories in delivery of health services;
- a national public hospital funding system involving the Independent Hospital Pricing Authority (IHPA) which will determine a national efficient price for public hospital services, a joint funding pool and a national funding body; and
- a nationally consistent Activity Based Funding (ABF) system using casemix classifications for each service provided to public hospital patients (except where the service is block funded) flowing to other health services over time.

Discussion

The AHHA is concerned these goals may not be met because:

- the meaning and impact of the state/territory 'system manager' role is not well-defined and may be overlooked in the development of legislation and regulations for the establishment of new entities at national levels (note the Commonwealth's introduction of legislation for the National Health Performance Authority without consultation with states/territories);
- the lack of information about how the 'efficient price' will be calculated, including an indexation factor to be used to calculate annual rises in hospital costs (as distinct from increases in volume), may diminish the opportunity to develop a fair and equitable methodology;
- the Commonwealth has disregarded the remarkable efficiency gains made by public hospitals over recent decades and, consequently, has unrealistic expectations of potential savings to be made. Further efficiencies will be difficult to achieve without compromising the quality and safety of care;
- an effective nationally-based casemix classification system cannot be realised unless data collections within and across jurisdictions are synchronised to mitigate against perverse incentives;

- while success of the funding mechanisms (and, indeed, the whole reform agenda) rests with an effective Independent Hospital Pricing Authority, there is insufficient technical and clinical expertise for the role; and

- political accountability for community and primary healthcare services remains confused with both Commonwealth and states/territories as providers and the funder and/or provider role of Medicare Locals (MLs) being unclear resulting in potential for duplication of, and gaps in, services.

2.2 Local governance

The AHHA supports the concept of shifting corporate and clinical governance closer to the community through local entities, Local Hospital Networks (LHNs) and Medicare Locals (MLs), together with networks of health providers, Lead Clinician Groups (LCGs).

If implemented well, LHNs, MLs and LCGs should enhance delivery of safe and efficient care through:

- integrated planning and delivery within and across jurisdictions, healthcare settings and professional groups;

- provision of incentives to ensure that care is given in the most suitable setting by the most appropriate provider; and

- engaging individual consumers and the community as active and informed participants in local healthcare processes.

Discussion

The AHHA is concerned that these goals may not be met because:

- the absence of mechanisms to ensure integration and coordination between the local entities, and the lack of detail about the aims of LCGs, weaken the capacity of these entities to work together; and

- it is wrong to assume that savings can be made through a community-based paradigm based on a belief that care in hospitals is inefficient, unless hospital demand management programs in community settings are created and funded.

2.3 Nationally consistent performance standards and reporting

The AHHA supports the establishment of national bodies that will drive consistent standards across jurisdictions leading to public reporting of outcomes because, in theory, these initiatives should lead to clearer accountability for the safety, quality and efficiency of healthcare delivery in all settings.

Discussion

The AHHA is concerned that these goals may not be met because:

- administrative data on how health services are delivered and counted, both between and within states/territories, needs to be standardised before data can be interpreted nationally and used for other purposes such as setting a national efficient price (currently the significant differences obstruct national analysis and use);
- linking patient-centric activity data sets between the Commonwealth Department of Health & Ageing, the Australian Institute of Health and Welfare and the new national bodies will be essential for the interpretation of service utilisation within and across sectors/ states/territories; and
- the significant challenges to setting health outcome indicators need to be overcome to achieve national conformity while also being sufficiently flexible to guide continuous improvement at the service delivery interface. Performance should be measured, not only by quantifiable outcomes, but also in terms of learning and improving, taking into account the views and feedback from the community[2]. Preferably, health services should have the capacity to put the service user first with the flexibility to meet local goals through continuous improvement. There is a danger that use of easily quantifiable standards which focus on visible parts of the system (eg emergency departments and elective surgery), while managing political risk, will create perverse incentives and less than optimal outcomes.

[2] 2010. Neville Ann. Implementation Challenges: performance management through KPIs. Policy Briefs 9; Crawford School of Economics and Government, ANU.

3. TRANSPARENCY OF, AND ACCOUNTABILITY FOR, FUNDING

3.1 Background

Australia's multi-level government funding system (Commonwealth, state/territory and local) has traditionally been a major barrier to achieving quality and cost effectiveness due to:

- duplication of bureaucratic, administrative and clinical services arising from the lack of role delineation between the various levels;
- reduced quality of patient care as patients are not necessarily treated in the setting most appropriate to their needs; and
- compromised continuity of care for patients moving between hospital and community or aged care sectors due to a lack of coordinated services.

The NHR will involve national funding for public hospitals and health services. Structures and processes will employ an Independent Hospital Pricing Authority (IHPA), a joint funding pool and a national funding body, all to be established from 1 July 2012. From 1 July 2014 the Commonwealth's contribution to hospital funding will be based on funding levels set by the Intergovernmental Agreement on Federal Financial Relations and the National Healthcare Agreement (2008) plus 45% of the growth in activity (admitted and non-admitted) at the agreed efficient prices, rising to 50% from 1 July 2017, supplemented by incentive and other payments included in the Agreement.

The AHHA is cautiously optimistic that these reforms will reduce or even eliminate the current deficiencies (above). However, implementation challenges (discussed below) will need to be overcome.

3.2 The Independent Hospital Pricing Authority

The role of the Independent Hospital Pricing Authority (IHPA) is pivotal to the success of the reforms, due to its responsibility for the following critical issues:

- developing the national efficient price using a cost weighted casemix system to determine the price for services (Activity Based Funding (ABF)):
    - to be introduced for admitted acute patient services by 1 July 2012. Initially, the funding will be according to state-specific prices, transitioning over time to a national efficient price; and
    - to be introduced for non-admitted services (emergency departments, subacute and outpatient services) also by 1 July 2012 but initially using nationally consistent activity 'proxies';

- providing advice to COAG on the definition and typology of public hospitals eligible for block funding only; mixed ABF and block funding; and ABF only and calculating the block funding levels for small and regional/rural hospitals;
- calculating Commonwealth funding levels for training and research activities and for public health programs; and
- developing the process of transition to the national efficient price and its timetable.

Discussion

Given the critical nature of this role:

- the Terms of Reference for the IHPA must reinforce its independence from all governments;
- establishing the IHPA with sufficient technical and clinical expertise will be a significant challenge, particularly in the agreed implementation timeframe. Canberra may not have the required skills base workforce for this task;
- understanding and dealing with the significant differences in how health services are delivered and counted both between and within states/territories (eg hospitals transferring patients between themselves as a network service) will be a significant challenge to overcome before costing and clinical data can be properly interpreted and applied;
- linking patient-centric activity data sets between the Commonwealth Department of Health & Ageing, the Australian Institute of Health and Welfare and the new national bodies will be essential for the interpretation of service utilisation within and across sectors/ states/territories; and
- determining how price is linked to quality is another critical issue requiring significant clinical advice. An 'efficient price' which does not adequately take account of investment in quality, innovation, research and teaching, will risk taking hospital services backwards in terms of access to the most effective treatments and technologies to support efficient and high quality care. For example:
    - a hospital that has a ward pharmacy service and dispenses most of its medications (rather than an impress model) will have higher pharmacy costs but less medication errors; or
    - hospitals that do an operative cholangiogram will have a longer time in operating theatre but less retained stones when performing a cholecystectomy.

***<u>The AHHA recommends that</u>**:*

- *the IHPA be established in a major capital city (other than Canberra) to capture requisite, independent expertise;*
- *in order to ensure nationally consistent patient-centric data collections as soon as practicable, high level clinical and statistical expertise be applied to developing systems that:*
    - *harmonise data collections both between and within states and territories so that differences in counting data and in service delivery can be moderated;*
    - *create linkages between data sets held by the Commonwealth Department of Health & Ageing, the Australian Institute of Health and Welfare and all new national bodes yet to be established so that service utilisation within and across sectors and states/territories can be analysed;*
    - *are informed by specific research into quantifying investments in quality, innovation, research and teaching for incorporation into the 'efficient price'.*

3.3 The National Efficient Price

The 'efficient' price will be based on the cost of the 'efficient' delivery of public hospital services, adjusted 'for a small number of loadings, to reflect variations in wage costs and other legitimate and unavoidable inputs which affect the costs of service delivery. These inputs include: hospital type and size; hospital location, such as regional and remote status; and patient complexity, including Indigenous status'.

'Efficient growth funding' will be comprised of the increase in the 'efficient price' for:

- delivering public hospital services (cost of services) plus the increase in service provision based on activity (volume);
- delivering services subject to block grants; and
- delivering teaching, training and research.

This funding will be paid prospectively to LHNs according to their Service Agreement with the state/territory government, subject to states/territories making a substantive contribution prior to Commonwealth payment. A retrospective reconciliation will take account of variations in actual services delivered[3].

[3] States will not be required to match the Commonwealth contribution but will have to report any variations from the national ABF system as well as in contributions to block grants, teaching, training and research.

Discussion

The AHHA is concerned that:

- there is no information in relation to indexing the 'efficient' price, which will need to be applied to the base funding. Given the short timeframe for the IHPA to be established and also to deliver on the national efficient price, a responsive mechanism must be put in place to review prices at a minimum of quarterly each year in the first few years of operation, after which time it should revert to an annual cycle. This is an area of high sensitivity that could be the 'Achilles Heel' of the whole reform process;

- the Commonwealth is likely to encounter a level of inefficiency which conflicts with the aims of the reforms by making payments adjusting for variations to LHN Service Agreements directly to individual LHNs rather than to the state/territory governments. Furthermore, it is more correct to make adjustment payments to the state/territory as, being system managers, they would have already made financial provision for the imprecision of casemix costing and the wide variation in LHN capacity; and

- the Commonwealth may have an unrealistic expectation of possible savings to be made out of hospital activities because Australia's public hospitals have achieved remarkable efficiency gains in recent decades such that further efficiencies will be difficult to achieve. Between 2005-06 and 2009-10 the rate of available beds in Australia remained steady at about 2.5 per 1,000 head of population while the number of ED presentations increased significantly with over a quarter of these patients being admitted. Overall demand on emergency departments increased by 17% during this period and is likely to continue at this rate. For overnight separations, the average length of stay was 5.9 days in 2009–10, down from 6.2 days in 2005–06[4]. Furthermore, evidence shows that the adjusted cost of service delivery is very similar across jurisdictions despite decade-old differences in funding methodologies. This result can be viewed as arising from one of the most important natural experiments in Australian health funding: for example, Victoria funds by casemix; NSW funds by a mix of needs-based funding and casemix and Queensland funds by cost-based historic funding.

[4] 2011: Australian Hospital Statistics 2009-10, Australian Institute of Health and Welfare: Canberra

***The AHHA recommends that**:*

- *the 'efficient' price be indexed. In line with past National Healthcare Agreements this indexation, applied to the base funding, must be transparent, acceptable to all parties, and take into account the cost of non-volume-related costs such as quality care, expanding medical and communication technologies and increasing private health insurance premiums. National Partnership payments must not be included in the calculation of the base efficient prices. The following indices (or other replacement measures) should be applied quarterly in the first few years of operation, followed by annually:*
    - *The AIHW health price index;*
    - *The Productivity Commission index of technology growth;*
    - *Projected increases in population by region adjusted for likely hospital utilisation (which will not be covered totally by volume growth);*
- *the Commonwealth adjustments to variations in LHN Service Agreements be paid in aggregate directly to the states/territories.*

3.4 The National Funding Pool

The AHHA supports the concept of a single National Funding Pool (to include both base and activity-based growth funding plus additional streams when agreed by COAG) to be established by 1 July 2012 and administered by the independent national funding body. While this Pool will have identifiable state/territory accounts, this structure should enable transparency of payments from both levels of government.

Discussion

The AHHA is concerned that construction of such a national funding body will be difficult without incurring significant transaction costs and liquidity problems.

3.5 Activity Based Funding (ABF)

The AHHA supports the concept of ABF being applied to all services because it has potential to influence appropriateness of care and improve efficiency. On the other hand, ABF is capable of causing significant perverse incentives if not implemented strategically and consistently.

Discussion

The AHHA is concerned that:

- inability to link administrative and hospital activity data arising from separate episodes of patient care means that the aggregate cost of the particular treatment regime cannot be calculated and used for funding

purposes. Treatment for a single condition frequently involves providing care across several hospital admissions as well as in non-admitted settings, but the current 'episodic' based funding approach encourages care to be fragmented across these multiple episodes with each component resulting in a separate cost. This also leads to gaming and reduced productivity;

- inpatient funding according to the 698 Australian Refined Diagnosis Related Groups (AR-DRG)[5] inadequately reflects the costs of highly complex conditions. For example:

    - many inpatient DRGs have sub-groups of very complex patients that incur significantly higher treatment costs. While detail in the inpatient data can identify many of these high cost patients, this information is frequently not used in the calculation of inpatient costs. However, it should not be assumed that these more costly patients average out across hospitals. A funding system that does not take this issue into account could result in hospitals reducing the number of high cost specialist services, thus impacting negatively on quality and efficiency; and

    - there are examples where more specific DRGs are needed, particularly to distinguish between elective and emergency admissions;

- understanding and dealing with how ABF systems for non-admitted patients are constructed will be a significant challenge to overcome requiring significant clinical advice, as there is the potential for significant skewing of incentives resulting in some patients being treated inappropriately as inpatients; and

- a separate approach to mental health funding, which has not been included in the immediate reform agenda, will be needed. Careful attention will be required in the development of specific classifications. The AHHA does not support the use of the AR-DRG system for inpatient mental health.

***The AHHA recommends that**:*

- *systems to link costing data and hospital activity data arising from separate episodes be established in order to calculate and fund the aggregate cost of a treatment 'package';*

- *high level expertise be applied to constructing the ABF systems for non-admitted patients to ensure incentives result in appropriateness of*

[5] National Hospital Cost Data Collection (NHCDC). Department of Health & Ageing

treatments and settings and to minimise the potential to treat some patients as inpatients instead of non-admitted patients;

- *detailed work be undertaken to:*
    - *identify DRG sub-groups of very complex patients to prevent these highly specialist services that treat some of the most critical patients from being financially penalised;*
    - *create more specific classifications, particularly to distinguish between elective and emergency admissions;*
- *a discrete ABF classification be developed that can be used across all mental health settings (inpatient, outpatient, community and residential) and which builds a funding model that neutralises the incentives to treat patients in inpatient settings if they can be appropriately treated in other settings.*

4. LOCAL GOVERNANCE

4.1 Integration and coordination

One of the most important potential outcomes of the health reforms is the strengthening of local decision-making through establishing Local Hospital Networks (LHNs) and Medicare Locals (MLs). It is hoped that these new structures will respond to the key challenges of our health system:

- how to achieve better integration and coordination across all types of care (acute, transition, sub-acute, rehabilitation, community, primary, aged); and
- how to achieve the best balance of investment across these care types.

Discussion

The AHHA is concerned that:

- the original proposal that boundaries between LHNs and MLs be contiguous wherever possible, to assist with integration of services and care coordination, appears to have been dropped in recent establishment plans;
- successful implementation of the health reform agenda will rely on effective cross-boundary work at the local level to integrate and coordinate care, but there are no defined mechanisms in the reform proposals to integrate and coordinate care or for recognising existing initiatives and networks [6]:
  - a well-integrated health system is not one without boundaries, but where relationships across the boundaries between the different parts of the health system (service agencies, programs or levels of government) enhance service quality and efficiency[7]. Poor integration can distort the allocation of resources, lead to inefficient practices and work against best practice care and continuity of care. It is not clear which entity will manage and fund patient care where a seamless interface between hospital, community services and home is required, such as in rehabilitation, palliative care and mental health services; and
  - care coordination has been defined as the deliberate organisation of patient care activities between two or more participants (including the patient) involved in the care to facilitate the appropriate delivery of

[6] 2010. O'Flynn Janine. Implementation Challenges: working across boundaries - barriers and enablers. Policy Briefs 9; Crawford School of Economics and Government, ANU

[7] 1991. National Health Strategy. The Australian Health Jigsaw: Issues Paper Number 1, p 14

services[8]. Poor care coordination can result in less than optimal outcomes for the patient who required guidance through carious services in the system. It will be critical to both maintain, where relevant, and establish new infrastructure and systems that foster close connections between providers in these entities. This will be particularly important in the establishment of Lead Clinician Groups (LCGs);

- the reforms do not anticipate the introduction of nationally consistent clinical practice guidelines, which could provide the mechanism needed for nationally consistent integration and care coordination, resulting in patients being treated in more appropriate settings, freeing up acute beds, reducing hospital lengths of stay, preventing duplicate services and enhancing staff, patient and family experiences. With the new focus on national standards, it would be appropriate and timely to establish a national strategy incorporating research, training, evaluation and systematic reviews. It will be important for clinical pathways to be developed collaboratively between MLs, LHNs and LCGs;

- effective information technology connectivity and good patient management systems which go across provider boundaries are essential to supporting integration and coordination of care;

- a flexible, appropriately trained and structured workforce is essential to meet existing and future demand for primary care and community based health services, requiring short and longer term workforce strategies in which the Commonwealth will need to take a leadership role; and

- all governments will need to invest in building the governance capacity of local Boards/Councils and to engender a shared knowledge and awareness of the health reforms and the requirements of the health system.

The AHHA recommends that*:*

- *boundaries of LHNs and MLs be synchronised, wherever possible, to assist in integrating service delivery and coordinating patient care;*

- *a research and development strategy be established to develop a set of nationally consistent/locally adaptable practice guidelines and clinical pathways, providing the mechanism to guide best practice integration of services between different settings and guide care coordination;*

[8] 2007. Closing the Quality Gap: a critical analysis of quality improvement strategies: Volume 7, Care Coordination. US Department of Health & Human Services.

- *a national and systematic analysis of existing service integration and coordination models be undertaken to identify those that are best practice, cost effective, scaleable and transportable across jurisdictions;*

- *LHNs and MLs, in collaboration with LCGs, be funded to foster and approve (against national guidelines) models of care which encompass the whole patient journey. These models of care would:*

    - *link primary and community-based care with hospital care, particularly for the management of chronic disease such as diabetes and heart failure;*

    - *identify services that are potentially substitutable allowing for regional decisions about which service is best placed to provide and fund care. Examples might include primary care ED attendances, outpatient departments and hospital issued drugs;*

- *common, shared electronic medical records, including standardised needs assessment tools be established;*

- *all governments invest in building the governance capacity of local Boards/Councils to engender a shared knowledge and awareness of the health reforms and the requirements of the health system;*

- *workforce reform focused on a multi-disciplinary team approach to care, underpinned with education and training programs, be accelerated.*

4.2 Medicare Locals (Primary Health Care Organisations)

The AHHA believes the future of primary health care is at a turning point but that this will depend on how Medicare Locals are established and operated.

The AHHA understands that the proposed functions of MLs are:

- regional integration including coordinating services at the local level to secure improved access to primary, acute and aged care services as well as after-hours services;

- service planning including addressing gaps and inequities;

- supporting the delivery of a range of primary health care initiatives;

- improving collaboration between practitioners and service providers; and

- providing health promotion and preventive health programs targeted to risk factors in communities.

Discussion

The AHHA is concerned that:

- reform documentation is silent on mechanisms to achieve these functions, relying instead on suggesting that MLs will operate, at least initially, as Divisions currently do; that is, a collection of programs being loosely managed rather than setting in place fundamental reform from the start. The mechanisms that would be used to support service delivery, provide after-hours primary medical care and fill gaps are unclear;

- there is a high risk of 'one-size-fits-all' if GP divisions are simply reinvented, rather than recognising the diversity and success of existing organisations, programs and partnerships. This interpretation was further reinforced with the controversial move to limit applicants for MLs to Divisions of General Practice only;

- while the Commonwealth anticipates that local population health and service plans will be developed over time, local population health and service planning should be the initial function of MLs on the basis that health system design begins with the community's needs which define the services required, in turn determining the details of how the system is organised and funded. In the absence of a strong tradition in Australia for undertaking such work, MLs would need considerable financial and professional support to build the required capacity and skill-sets. Currently, the vast majority of available health planning expertise resides in state and territory health departments. The AHHA argues that MLs must explicitly harness this expertise and will require considerable development money for capacity building that will also require financial compensation to states/territories to provide such advice/assistance; and

- governing Boards will need high level expertise to ensure effective and efficient corporate and clinical governance in the complex environment described above.

***The AHHA recommends that**:*

- *MLs recognise the diversity of primary health care services in their role and governance, given the fact that current linkages across the primary care sector, and between primary health care and hospitals, are predominantly provided by non-GP services;*

- *local population health and service planning be the initial function of MLs on the basis that relevant health services should meet the community's needs, in turn determining the details of how the system will be organised and funded.*

4.3 Local Hospital Networks

The LHNs will be single or small groups of public hospitals with a geographical or functional connection that are large enough to operate efficiently and provide a range of services while allowing for effective local management. The Networks will be administered by a Chief Executive and local Governing Council that will include clinicians, healthcare management experts and community representatives.

The LHNs will be responsible for negotiating a Service Level Agreement in partnership with the relevant state/territory. They will be accountable for delivering on that Agreement to both the state and Commonwealth governments as the Commonwealth component of the cost of services will be received directly by the LHN.

Discussion

The AHHA is concerned that:

- the LHN Governing Councils will need high level expertise to ensure effective and efficient corporate and clinical governance in this complex environment; and
- while the reforms envisage that the states and territories can manage the delivery of relevant GP and primary health care services where the Commonwealth agrees to provide those services through LHNs, the documentation does not define circumstances where this may occur. There should be nothing in the legislation that would prevent LHNs from delivering primary and community care as state-owned organisations currently do across the country and receive funding for these services. In this context, there is no reason to prevent LHNs from taking on the role of a ML in the form of Local or Regional Health Network over time.

***The AHHA recommends that**:*

- *LHNs reflect the diversity of public health care services in their role and governance, recognising that effective linkages between primary health care and hospitals are essential to the success of the reforms;*
- *LHNs in partnership with other organisations be allowed to apply to become combined ML-LHNs that resemble fully-integrated Regional Health Networks, reducing the likelihood of continued silos of planning and service delivery.*

4.4 Lead Clinician Groups

It is envisaged that LCGs will provide advice to the LHNs on service delivery, optimal models of care and methods to improve clinical outcomes. They will assist in adapting national clinical guidelines for local environments and in developing and/or identifying local innovations for national adaption.

<u>The AHHA recommends that:</u>

- *a balance of health professionals on the LCGs (not just doctors) be ensured together with a consumer perspective;*
- *LCGs be embedded in the LHN with funding and infrastructure backing to support their work, while at the same time ensuring inclusion of clinicians through the MLs;*
- *in establishing LCGs, established structures such as Clinical Networks and Senates which have been built up by each state/territory, are preserved and integrated into the new Groups.*

5. NATIONAL STANDARDS/REPORTING

5.1 National Performance and Accountability Framework

The new National Performance and Accountability Framework will underpin the key objectives of the reforms, addressing:

- increased transparency and accountability; and
- achievement of key national health policy objectives such as the improvement of safety and quality as well as efficiency and sustainability.

The Framework will encompass roles for the COAG Reform Council (CRC), the National Health Performance Agency (NHPA) and the Australian Commission on Safety and Quality in Health Care (ACSQHC), building one national system for performance and accountability.

Discussion

The AHHA is concerned that:

- a commitment from all governments to this Framework is critical to the successful implementation of the NHR;
- there is potential for duplication among existing (eg Australian Institute of Health and Welfare and the Productivity Commission) and new bodies without a stocktake, rationalisation and linking of existing data collections;
- information needs to be relevant to five broad categories: funders, providers/clinicians, research, social marketing and the public. Services and clinical groups must have easy access to the data for their own benchmarking purposes; and
- considerable challenges need to be overcome in the measuring of health system performance because:
    - reliable and sensitive health outcome measures need to be developed as matter of urgency but lack of available data limits the development of outcome indicators in favour of substituting process and output measures such as levels of expenditure, resources used or summary measures of population health (mortality and life expectancy);
    - performance is a multidimensional concept, encompassing a balanced scorecard of key performance indicators across health status and outcomes, determinants of health and health system performance including experiences of patients; and
    - processes must include measurement, analysis, benchmarking and reporting to funders, providers, clinicians and ultimately to the community. However, there is little value in producing outcome

reports unless the information is useful at the place of service delivery as well as at higher levels within the system.

The AHHA recommends that:

- *the AIHW and NHPA be commissioned to undertake a stock-take and evaluation of current data collections that support all components of the health care system including performance monitoring and benchmarking;*
- *appropriate processes for standardising and linking data collections are available to national bodies (AIHW and NHPA);*
- *a suite of nationally consistent key performance indicators be implemented to allow funders, health services and the community to assess performance reports (appropriately risk adjusted) of health services nation-wide;*
- *information be developed in five broad categories, specifically for each intended audience: funders, providers/clinicians, research, social marketing and the public. Researchers should have the capacity to access data for analysis and services and clinical groups should have access to the data for their own benchmarking purposes;*

5.2 National Health Performance Authority

Under the Performance and Accountability Framework, the National Performance Authority will set national standards and assess the performance of health services around the country. The Authority's functions, designed to complement the existing Review of Government Services process, the National Health Information Agreement and the Aboriginal and Torres Strait Islander Health Performance Framework, will be to:

- provide clear and transparent quarterly public reporting of the performance of every LHN, the hospitals within it, every private hospital and every primary healthcare organisation (ML), through the new Hospital Performance Reports and Healthy Communities Reports; and
- monitor the performance of LHNs, MLs and hospitals against these performance measures and standards in order to identify:
    - high-performing LHNs, MLs and hospitals, to facilitate sharing of innovative and effective practices;
    - poorly performing LHNs and MLs to the Commonwealth and states, to assist with performance management and improvement activities; and
    - develop additional performance indicators as appropriate, when asked by the Commonwealth Health Minister at the request of COAG.

Discussion

The AHHA is concerned that:

- the Commonwealth Government had failed to involve the states and territories in developing the Scoping Paper for the new Framework or the legislation to establish the NHPA, introduced into the Commonwealth Parliament on 3 March 2011 (Health Performance and Accountability Framework and *National Health Reform Amendment [National Health Performance Authority] Bill 2011*). If continued and applied to other reform elements, this lack of consultation will lead to suspicion and angst and undermine the whole reform process; and

- the legislation fails to recognise the formal role of state/territory governments as majority funders and system managers of public health services including overall responsibility (statutory and politically) for the performance of LHNs, public hospitals and state/territory primary health care services. These are complex areas of service delivery in which states/territories have considerable knowledge and expertise. As a result, the legislation has a number of critical flaws which will reduce its capacity to fulfil its role. This, in itself, is not in the interests of the Commonwealth Government. In particular, areas which must provide for involvement of states/territories and currently do not are: strategic planning; developing performance indicators to assess quality; and dealing with underperforming hospitals when necessary.

The AHHA recommends that:

- *immediate attention be given to amending the Health Performance and Accountability Framework and National Health Reform Amendment [National Health Performance Authority] Bill 2011 to take account of the formal role of states and territory governments as system managers of public health services; in particular (but not limited to), giving them a role in strategic planning, developing performance indicators and dealing with underperforming hospitals;*

- *the NHPA be required, in collaboration with AIHW, to undertake in its first year:*

    - *a stocktake/evaluation of current data collections;*

    - *immediate application of some well-developed indicators which can be used for performance monitoring and benchmarking;*

    - *a process for further developing data collections and analysis.*

5.3 COAG Reform Council

The COAG Reform Council is to provide public reporting about national and jurisdictional level performance and provide an independent assessment of whether predetermined performance benchmarks have been achieved prior to reward payments being made.

It is unclear to the AHHA how this role will be different from the NHPA.

5.4 Australian Commission on Safety and Quality in Health Care

Initially, Australian Health Ministers established the Australian Commission on Safety and Quality in Health Care to maintain national data sets and produce a biennial report on safety and quality. Under the reforms, the Australian Commission has been made permanent and its role expanded. It will play a lead role in developing, implementing and monitoring national clinical safety and quality standards.

Discussion

The AHHA is concerned that:

- with estimates of the cost of such adverse events in the Australian health system being in the order of $867 million per year, or 1.7 million bed days[9], urgent action is required and associated expenditure on workforce and systems justified; and
- there has been no follow-up study since 1995, when the Quality in Australian Healthcare Study found high levels of preventable incidents related to care in the Australian hospital system, which suggest that this pattern has been mitigated. There have also been no similar studies in community-based medical services. The 1995 findings showed that 16.6% of admissions to hospitals were associated with an adverse event involving an injury or complication arising from the healthcare being provided and 4.9% of these events resulting in death (a 2000 revision put the estimate at 10.6% of all admissions)[10].

<u>The AHHA recommends that:</u>

- *sufficient funding be made available for high level scientific research and evaluation on the measurement and improvement of patient care, health status and outcomes subject to regular reporting on national trends and disparities in quality;*

[9] 1996. Final report to the Hon Dr Michael Wooldridge MP, Minister for Health and Family Services, Taskforce on Quality in Australian Health care; Commonwealth of Australia

[10] 1995. Wilson, R.M. et al. The Quality in Australian Health Care Study: Medical Journal of Australia;163:458-471

- *a once-off upgrade of information systems be implemented to improve capture and reporting of adverse events and then quarterly analysis, at the national level, of data on adverse events;*
- *active consumer involvement be ensured in the development and use of indicators and data collection systems;*
- *workforce reform focused on a multi-disciplinary team approach to care, underpinned with education and training programs, that encourages a culture of safety and greater openness in the system;*
- *evidence-based practice be incorporated as part of routine service delivery across all sectors.*

6. OTHER ISSUES

6.1 Incentives for Emergency Department Waiting Times & Elective Surgery Waiting Lists

AHHA members have raised concerns regarding the potential of unintended consequences arising from targets for elective surgery and emergency department waiting times.

The concerns include the potential that consumer expectations linked to targets might result in even greater pressures on public hospitals. For instance, a 'guarantee' committing to targets for providing elective treatment in public hospitals within a certain period of time could lead to significant additional demand on services, lengthening of waiting lists and a further reduction in people willing to take on and use private health insurance as an alternative.

For emergency departments, similarly, a 'standard' for being seen and/or treated within four hours may have consequences for the number of people with varying levels of acuity attending public hospitals. This would be felt more intensely in jurisdictions and regions where community-based services are under-resourced, for instance where there are insufficient general practitioners.

The AHHA is calling for key performance indicators that not only facilitate national conformity, but are also sufficiently flexible to allow for best practice care and to guide continuous improvement at the service delivery interface. Performance should be measured, not only by quantifiable outcomes, but also in terms of learning and improving, taking into account the views and feedback from the community[11]. Preferably, health services should have the capacity to put the service user first with the flexibility to meet local goals through continuous improvement. There is a danger that use of easily quantifiable standards which focus on visible parts of the system (eg emergency departments and elective surgery), while managing political risk, will create perverse incentives and less than optimal outcomes.

6.2 Evaluation

A significant oversight in the whole reform agenda is the lack of an evaluation program. Without a systematic method for collecting, analysing and using information to answer questions about the effectiveness and efficiency of the multiple elements of the reform program, the achievements of the reforms, particularly in terms of patient outcomes, will not be known.

In the context of interaction with patients and providers, it is imperative that quality and outcome indicators, along with access measures, are incorporated into a formal evaluation program from the outset.

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[11] 2010. Neville Ann. Implementation Challenges: performance management through KPIs. Policy Briefs 9; Crawford School of Economics and Government, ANU.

The AHHA is calling for a National Evaluation Framework to complement the NHR with dedicated funding to ensure that research can generate the necessary evidence to assess the outcomes of the reforms and, where necessary, indicate where changes need to be made. Research under this Framework should be linked directly to the Local Hospital Networks and Medicare Locals so that health services can collaborate with researchers in their local area and be supported to undertake research of their own.

To improve health services for the public there is a need to engender a research culture within health services for those in health management roles as well as all clinicians. Research on the ground is often hindered by time, money, understanding and the support necessary to undertake research.

A particular focus for the AHHA and its members is to ensure measurement of the impact of reforms on hospital demand in particular. There is no doubt that in the coming years this will be one of the major cost pressures in health.

6.3 Hospital Demand Management

There is no coherent strategy to manage hospital demand within the reform mechanisms. The worst outcome would be parallel systems of primary and hospital delivery that achieves none of the intended service integration. A recent study by Associate Professor Ian Scott[12] found that if current bed use trends persist there will need to be a 62% increase in hospital beds by 2050 to meet expected demand, at a cost almost equal to the entire current Australian healthcare budget. The Australian Institute of Health and Welfare estimates the number of Potentially Preventable Admissions (PPHs) to public hospitals in 2009–10 as 515,232, 10.2% of all separations[13]. More than half were due to chronic conditions.

The Scott study found that the biggest gains in reducing hospital demand will come from improved access to residential care, rehabilitation services and domiciliary support. This means that, in a technical sense we should be able to prevent avoidable admissions using quite simple straightforward strategies such as:

- enhancing the health management, within community settings, for the growing numbers of Australians who are ageing and who have chronic illnesses - to reduce the incidence of acute preventable deterioration requiring hospital admission;

[12] 2010. Scott Ian A. Public hospital bed crisis: too few or two misused? The Australian Health Review: Vol 34; Issue 3; p 317-324

[13] 2011. Australian hospital statistics 2009-10; Australian Institute of Health and Welfare: Canberra

- improving health and medical care arrangements for people living in residential aged care facilities so that residents are not ambulanced to a public hospital when a preventable crisis occurs; and

- facilitating coordination and communication between hospitals, general practitioners, private specialists and community-based support services so that people don't relapse after discharge from hospital and then require re-admission.

The AHHA is calling for a nationally funded hospital demand management program including elements of research, consultation, implementation and evaluation.

6.4 eHealth and data collection

From being an early leader in its ability to manage and use health information, Australia is now increasingly falling behind comparative countries such as the UK, Canada and the US.

In order to be fully effective, the reforms will need a sophisticated electronic health information system to underpin the various activities. For example, the requirements for measurement and reporting, activity-based funding and integration of patient care between LHN and ML services will be substantial. Currently, this infrastructure does not exist. Unless this infrastructure is built, opportunities presented by the reform process could be lost.

It seems clear from the experience elsewhere that substantial initial investment is required before returns are seen but once this investment threshold is passed the returns far exceed the costs.

The Association is calling for the parallel development and implementation of a comprehensive National E-Health Strategy focused on accelerating the current health information infrastructure work program, building a sufficient labour force in health informatics and health information management and establishing clear milestones with routine reporting on progress.

Funding in the last Commonwealth Budget (11 May 2010) which provided $467m (over 2 years) to implement a personally-controlled Electronic Health Record is only a small, albeit important, start to implementing the National E-Health Strategy.

Implementation of a comprehensive e-health system also requires a range of specialised human resources. These include:

- clinicians who understand e-health technologies and can apply them to clinical practice;

- information technology professionals with in-depth knowledge of both the business and clinical needs of the health system;

- health information management professionals with knowledge of e-health technologies;
- planners who know how to utilise health information systems to address system management issues; and
- specialists in process re-engineering and change management.

6.5 Private patients in public hospitals

Hospital funding currently includes funding for the gap between health fund payments and cost. How this gap (subsidy) is to be funded has not been outlined in the reform proposal. Indeed, the National Heads of Agreement does not anticipate any change to the financial arrangements in respect of private patients in public hospitals.

The amount of funding involved in this issue varies between the states because of different minimum benefits paid by health insurers and different rates of private patients in public hospitals. However, the issue is critical for some states, where there is a large gap between the price paid by health funds for private patients in public hospitals and actual costs. Health funds pay about 1/3 of the cost for most private patients.

The level of private patients in public hospitals also has industrial implications with staff specialist income linked to private patient income levels in many states.

The AHHA is calling for further research to be undertaken to clarify and resolve the funding implications for treatment of private patients in public hospitals, and to resolve any necessary consequences.

6.6 Indigenous health

Health outcomes for Indigenous Australians are so much worse than those of other Australians that this issue can only be described in the strongest terms:

- the life expectancy of Aboriginal Australians is 17-20 years less than that of other Australians;
- there are nearly three times as many deaths among Aboriginal Australians as would be expected for the population as a whole; and
- Indigenous Australians experience an earlier onset of most chronic diseases, have more GP consultations and are more likely to be hospitalised than other Australians.[14]

Significantly, Australian Indigenous health status not only lags behind the general Australian population, it lags behind that of comparable populations in

[14] 2005. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples: ABS

other countries such as the United States, Canada and New Zealand.[15] There is a well-recognised nexus relating poor Indigenous health to inadequate investment in infrastructure and the need for community-controlled services.[16] Housing and educational opportunities for Aboriginal people fall below the standard expected by the broader community.

The specific application of these issues in healthcare include on-going barriers in Indigenous access to the Medicare and the Pharmaceutical Benefits Schemes, contributing to substandard levels of healthcare service provision[17] and an under-representation of Aboriginal people among the ranks of healthcare workers.

The AHHA is calling for significant funding increases for Indigenous-specific healthcare services. The bulk of this funding should be directed towards improving the provision of culturally appropriate primary healthcare and should be provided via mechanisms which promote Aboriginal peoples' control over their own health, including through funding to Aboriginal community-controlled health services.

6.7 Community engagement in developing policy options

A nation's health policy should aim for 'optimal' health for its population. This term recognises that while it is technically possible to achieve health gains for some individuals in a community, it is not always possible to deliver the required services because of resource constraints. Even with this recognition, further clarification of the idea of 'optimal' is required. For example, does our community wish to invest in an initiative which may result in a large net, but small individual, improvement in the health of the community as a whole? Or, would the community prefer a smaller net, but larger individual improvement, in the health of that section of the community with the worst health outcomes? This question is far from theoretical.

To date there have not been clear objectives for the Australian healthcare system. To the extent that objectives have been considered there has often been a lack of community consultation and transparency. The issue of engaging the community in determining what its health priorities are is a major challenge for Australia's health policy.

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[15] 2002. Paradies Y, Cunningham J. Placing Aboriginal and Torres Strait Islander mortality in an international context: Aust N Z J Public Health

[16] 2004. Griew R, Sibthorpe B, Anderson I, et al. On our terms: the politics of Aboriginal health in Australia in Healy J, McKee M, editors. Accessing health care: responding to diversity. Oxford: Oxford University Press

[17] 2005. Joan Cunningham, Alan Cass and Peter C Arnold. Bridging the treatment gap for Indigenous Australians: Med J Aust; 182 (10): 505-506)

These issues are not discussed in this paper other than to note the AHHA's view that new policy initiatives must be considered and implemented if broader health sector reforms are to be effective.

6.8 Medical workforce

The health workforce as currently constituted is unable to cope with epidemiological, demographic and technical changes in health service provision and demand.

The AHHA is aware of the Health Workforce Agency's program and will not comment in this paper except to point out that the reform agenda does not adequately deal with critical issues surrounding the medical workforce in particular. Present arrangements often allow the preferences of medical practitioners (particularly out-of-hospital specialist services) to be the tail that wags the dog.

There is a need for focussed new policies concerning the distribution and training of doctors. Specific issues include the endemic shortage of general practitioners in rural and regional areas and the growing 'super-specialisation' in specialist areas which impairs development of critical services such as after-hours emergency care and sustainable specialist units in regional areas.

A distorted Medicare Benefits Schedule and the growing private insurance sector allow GPs to congregate in attractive prosperous localities and specialists to practice in lucrative niches while significant portions of the population remain grossly underserviced without any commitment to broader health system priorities.

These issues are not discussed in this paper other than to note the AHHA's view that effective and no doubt controversial new policy initiatives must be considered and implemented if broader health sector reforms are to be effective.

6.9 Private Health Insurance

The AHHA believes there is a need to re-vitalise the 'health insurance' role, analysing health and financial risks across the system and developing national strategies to address them.

This paper does not explore the role of private health insurance in the proposed system. Arguably, if current initiatives are maintained (including the private health insurance rebate), the use of taxpayer dollars are being used inefficiently to support the private health insurance industry rather than healthcare providers themselves. The AHHA would prefer a system where the billions of dollars spent annually on the rebate would be drawn back into the health funding bucket and used to finance healthcare directly (which would include both public and private services).

6.10 Mental health

Mental health services are the most complex set of health services, covering birth to death, prevention, early detection, treatment and co-morbidities with the largest array of clinical and human services care partners. The scale of mental illness is huge, mostly arising in adolescence or youth, accounting for a third of the burden of illness, with about 40% of all disability (physical and mental) being due to mental illness. About one third of those presenting to GPs have mental health problems. The cost to the Australian economy is about $20 billion each year[i18].

Mental health service provision crosses numerous Commonwealth, state and territory agencies and service providers. The range of service provision locations and the number of agency providers involved in mental health care limits the ability to provide a continuity of care that is integrated and person-centred.

Recognising the establishment of the National Mental Health Advisory Council, there is still no single agency, organisation or level of government with the remit and responsibility for the setting of strategic mental health policy or for oversight, monitoring and operationalisation of mental health care. Funding methodologies and amounts vary between jurisdictions and have traditionally not been based on population need. This, and the range of agencies and providers involved in the provision of mental health care, has led to inequities in access, service provision, quality and health outcomes.

Best-practice care provision should occur across a continuum and be provided by clinicians in an integrated and coordinated fashion – a challenge for the current system with its multiple providers, funding and governance structures.

The allocation of sufficient funds to provide accessible and high-quality mental health services is also a major problem addressed by many investigations and reports, and in spite of recent increases in funding by Commonwealth and state/territory governments, the level of recurrent and capital expenditure is well below the investment needed.

The AHHA believes that mental health care provision requires a unique approach due to the burden, complexity and scope of mental health services and that current funding methodologies (particularly 'fee-for-service' arrangements) do not drive collaboration, continuity, integration and quality of service provision across the range of mental health service providers.

[18] 2006. Improving Mental Health Outcomes in Victoria – The Next Wave of Reform. Boston Consulting Group, Victorian Government

6.11 Oral and dental health

Dental and oral health is a vital component of overall health and well-being. Dental problems affect people's ability to eat (nutrition), socialise, find employment and fully participate in society. If untreated, dental problems can develop into more serious health conditions requiring intensive treatment and sometimes hospitalisation. Dental care is one of a few elements of public healthcare that is not covered by the reform agenda. Yet gum disease and dental caries account for two of the top five main public health issues in Australia[19].

Almost half a million people are on waiting lists for public dental treatment, with an average waiting time of 27 months and some up to 7 years. It makes no health or economic sense to allow people to languish without access to regular preventative dental care and treatment.

Many people who start out on waiting lists for preventative or restorative treatment become emergency cases by the time they receive treatment. Often they 'choose' or are effectively compelled to have their teeth removed due to financial, staffing and other resource pressures in the system.

This crisis is reflected in:

- over 400,000 adult concession card holders having teeth extracted in any 12 month period[20];
- over 17,000 children aged 0-9 years admitted to hospital for dental treatment under general anaesthetic in 2003/04 – 350% more than in 1993/94[21]; and
- over 20% of people in residential aged care facilities in pain or discomfort from untreated dental conditions[22].

Using dental health as a demonstration of improved funding and workforce planning will allow for smaller-scale exploration of issues around better integration across primary and acute settings, resulting in better cost efficiency through more appropriate use of human and financial resources.

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[19] 2001. Oral Health of Australians – National Planning for Oral Health Improvement: Final Report: Australian Health Ministers Advisory Council (AHMAC) Steering Committee for National Planning for Oral Health, South Australian Department of Human Services, Adelaide

[20] 2007. National Survey of Adult Oral Health (Unpublished data): Australian Research Centre for Population Oral Health, University of Adelaide

[21] 2006. Jamieson LM & Roberts-Thomson K. Dental general anaesthetic trends among Australian Children: BMC Oral Health, 6:16

[22] 2000. Chalmers JM, Hodge CP, Fuss JM, Spencer AJ & Carter KD. The Adelaide Dental Study of Nursing Homes 1998: AIHW cat. no. DEN 83, AIHW Dental Statistics and Research Unit (Dental Statistics and Research Series No. 22), Adelaide

The AHHA is calling for the establishment of a National Oral Health Leadership Taskforce that will have responsibility for:

- advising on the scope and implementation of public dental health programs (such as the Commonwealth Dental Health Program and Medicare Teen Dental Plan); and
- national workforce planning and coordination (including training).

The Association also recommends monitoring and evaluation processes to be established for the Commonwealth dental programs. This could be achieved at relatively low cost using pre-existing systems and data collection mechanisms. Failure to introduce evaluation strategies during early stages of the programs will result in limited or no capacity to monitor and assess the value/impact of the programs. More effort should also be invested in bringing more consistency to cross-jurisdictional reporting.

It is critical that the dental workforce environment be of maximum flexibility to allow for improved multi-disciplinary care, using national registration for all professions, in which there will be increased efficiency in the use of public and individual patient funding for dental care. This is a goal of the National Oral Health Plan that requires renewed attention.

6.12 Priorities for research

The AHHA believes that efficient delivery of services will only occur in an environment which encourages innovation and demands evidence-based policy making and practice.

In this context, the following priority areas require immediate research:

- situations in which multidisciplinary care is cost-effective, so that policies to foster this model can be developed where it is found to be beneficial;
- infrastructure requirements to support more community-based services involving a multi-disciplinary team-based approach so that policies can be developed to establish and fund appropriate facilities and information/communication technologies;
- the health needs of an ageing population so that strategies to meet these needs can be developed;
- the health access paradox whereby those with the greatest need are least able to access health services, particularly Aboriginal and Torres Strait Islander populations, so that policies to redress the inequities can be developed;
- the use of information and communications technology so that policies can be developed to realise its benefits in linking all services and to mitigate the high risk of program failure in this area;

- the disproportionate growth in unplanned health appliance and pharmaceutical costs at the expense of other health services so that policies can be developed to manage these expenditures; and
- implications of changes in workforce numbers and the fact that workforce per capita may overestimate workforce availability due to increases in part-time work, changing lifestyle expectations of healthcare workers, ageing of the population and hence the workforce, concerns about the need for safer working hours and workforce feminisation.

APPENDIX 1

Background to the health reforms

The health policy agenda of most nations is dominated by four main goals: improving the health status of the population, universal and equal access to health services of similar quality, control of costs and effective and efficient use of resources.

Impacting on the achievement of these goals is the rapid development of innovations arising from advances in health and medical research which generate: radical reshaping of treatments and procedures, far-reaching restructure of institutions (including hospitals which have become centres of sophisticated and costly technology), and fundamental redesign of healthcare professionals' roles (including the concerning increase in specialisation).

In the National Health and Hospitals Reform Commission Report (2010) the case for health reform was argued on the basis that the Australian health system was under increasing pressure from:

- increase in demand for, and expenditure on, health care;
- unacceptable inequities in health outcomes and access to services;
- growing concerns about safety and quality;
- workforce shortages; and
- inefficiency.

The Commission also cited the problems arising from a fragmented health system with a complex division of funding responsibilities and performance accountabilities between different levels of governments.

Australian reform 2010-11 summary

Calls for reform of the Australian system have been emanating from governments, stakeholders, health professionals and the community for a number of years. The AHHA has been one of these voices, strongly advocating for improved national consistency of hospital funding along with greater transparency and accountability, as the key to driving better service quality and planning.

In March 2010, the Prime Minister (Kevin Rudd) announced a comprehensive set of reforms based on the NHHRC report plus results of a community consultation program. Subsequently, he reached agreement with Premiers and Chief Ministers of states and territories (with the exception of WA) at the Council of Australian Governments (COAG) meeting in April to reform Australia's health system by establishing the National Health and Hospitals Network.

WA's main objection to the reforms was the Commonwealth's proposal to fund the initiatives with a 30% (approximately) claw-back of GST funding. In November 2010, the newly elected Victorian Liberal Government joined WA in eschewing the reforms.

In order to establish consistency among all states, the Commonwealth, under the Prime Ministership of Julia Gillard, revised the reform proposals considerably for the COAG meeting of 13 February 2011. This meeting discussed a revised reform package and agreed to a Heads of Agreement – National Health Reform.

In the view of the AHHA, it is highly unlikely that further change will be initiated by the Commonwealth Government. Further reform will now need to be spearheaded by all jurisdictions working together.