

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

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

Question no: 51

OUTCOME 13 Acute Care

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

How will decisions be made about what proportion of new subacute beds will be allocated for mental health, geriatric, rehabilitation or palliative care and who will make these decisions?

Answer:

The Commonwealth will expect States and Territories to plan the delivery of the new beds to ensure they are distributed according to local need and take into account any nationally identified subacute care benchmarks.

States and Territories will also be expected to actively engage those sectors involved in the delivery of subacute services in the development of Implementation Plans and throughout the duration of the April 2010 COAG subacute reforms.

States and Territories will be required to submit detailed implementation plans for this subacute funding, for approval by 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: 52

OUTCOME 13 Acute Care

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

What proportion of the subacute care beds will be allocated for each of these areas [mental health, geriatric, rehabilitation, palliative]?

Answer:

The proportion of the subacute care beds and bed-equivalents in the community to be allocated across the care types has not yet been nationally agreed.

In delivering the new subacute care beds, States and Territories are expected to improve the mix of services available taking into account a range of factors including local needs and any nationally identified subacute care benchmarks.

States and Territories will provide Implementation Plans, for approval by the Commonwealth, detailing the approach to be taken to delivering new additional beds across their jurisdictions, including the proposed distribution of funding and beds by care type.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

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

Question no: 53

OUTCOME 13: Acute Care

Topic: HEALTH REFORM

Written Questions on Notice

Senator Fierravanti-Wells asked:

How will the Commonwealth ensure that the States are accountable for using new public hospital funding to expand hospital capacity, beyond the targets proposed for elective surgery and emergency waiting times? What monitoring processes and timeframes will be put in place to support the accountability and transparency of this activity?

Answer:

Elective surgery and emergency department capital initiatives will be administered through a National Partnership Agreement. States and Territories will be required to submit detailed implementation plans, for approval by the Commonwealth, outlining projects to be funded.

The delivery of funding to States and Territories would be contingent on receipt and acceptance of implementation plans and progress reports over the life of the initiatives. Progress reports would provide ongoing updates on the progress in delivering projects identified in implementation plans.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

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

Question no: 54

OUTCOME 13

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

What transitional arrangements will be put in place to ensure hospitals that do not currently operate under casemix are able to adjust without compromising access to public hospital services or risking patient care?

Answer:

The Independent Hospital Pricing Authority (IHPA) will provide advice to COAG on the process of transition from state-specific prices to a national efficient price, and on the length of time for this transition.

Some hospitals that do not currently operate under casemix are likely to fall under Community Service Obligations (CSO) which are to be agreed by COAG. These hospitals will receive a mix of block funding and/or Activity Based Funding as appropriate.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

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

Question no: 55

OUTCOME 13

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

How will the pricing authority ensure that States do not end up paying significantly more than 40% of the efficient cost of services in order to cover the actual costs of providing hospital care?

Answer:

The determination of national efficient prices will be based on actual hospital cost data provided by States and Territories.

The Independent Hospital Pricing Authority will calculate state specific prices and national efficient prices in a manner which ensures reasonable access to public hospital services, clinical safety and quality, efficiency and effectiveness, and financial sustainability.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

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

Question no: 56

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

How will targets be defined so that they recognise situations where longer periods in emergency departments are in the best interests of the patient?

Answer:

- Under the Four Hour National Access Target, patients presenting to a public hospital Emergency Department (ED) are to either be admitted to hospital, referred for treatment, or discharged within four hours, where it is clinically appropriate to do so. The provision of quality of care is considered to be paramount and is part of any decision taking into account clinical appropriateness.
- Work will be undertaken to develop the national access target in consultation with the clinical community, and with reference to national guidelines on the circumstances in which it will be clinically appropriate to hold someone for longer than four hours in an emergency department. For example, it may be appropriate to have someone under observation for a longer time to allow proper diagnosis and referral.
- There are two further caveats to the Four Hour Target. EDs will retain the right to refer patients to a primary care setting, such as GP clinics, again where it is clinically appropriate to do so. Should a patient decline to be referred and exercise their right to be treated in the ED, this could result in the 4-hour clock being reset to zero.
- Also, application of the four hour target will be moderated in remote and other areas of Australia where there is significant undersupply of GPs and significant impediments to accessing a GP (and therefore where people are more likely to rely on doctors working in emergency departments for GP-type care). Application of the target in these circumstances will be agreed between the Commonwealth and individual jurisdictions, and be subject to periodic review.
- Some states have already moved to implement four hour models with 'proxy' compliance benchmarks of 95% and above. These benchmarks recognize that there will be cases where it is clinically appropriate to keep people for longer than four hours in an ED.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

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

Question no: 57

OUTCOME 13: Acute Care

Topic: HEALTH REFORM

Written Questions on Notice

Senator Fierravanti-Wells asked:

What measures will be taken to prevent perverse behaviour, given that targets and reward payments resulted in gaming and data manipulation as revealed by the Victorian auditor general was happening in Victorian public hospitals under similar arrangements?

Answer:

- Clause D10 of the National Health and Hospitals Network Agreement provides that: "States will take responsibility for the data integrity within their systems, and agree to establish appropriate independent oversight mechanisms for data integrity, to provide certainty to the Australian public about the actual performance of hospitals."
- This is in addition to clause A26 which provides that: "States will be accountable for financial management and audit of LHNs and will ensure that stringent independent oversight and financial accountability is put in place."

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

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

Question no: 58

OUTCOME 11 Mental Health

Topic: HEALTH REFORM

Written Question on Notice

Senator Fierravanti-Wells asked:

What role will Local Hospital Networks play in providing mental health services and how will these services be integrated with other primary and acute care services through Medicare Locals?

Answer:

It is expected that where hospitals currently provide hospital services to people with mental health conditions that they will continue to do so as part of Local Hospital Networks (LHNs).

Under the National Health and Hospitals Agreement there is a range of mechanisms to support integration across health services and these are all applicable to the provision of mental health services across both LHNs and primary care, including the involvement of Medicare Locals

For example, the Agreement provides that ... the Commonwealth and States will work together on system-wide GP and primary health care policy ... because of the need for effective integration across Commonwealth and State funded health care services;

And that:  
in relation to the services where funding and policy responsibility is transferred to the Commonwealth:, and where “coordination is required for reasons of ... service integration, the Commonwealth and the relevant State will work together to develop an agreed implementation plan” and “the Commonwealth will develop a policy framework for these services in consultation with the States”.

It is relevant that the Agreement also provides that:  
“The Commonwealth and State governments will work together to create linkages and coordination mechanisms between [Medicare Locals] and other State services that interact with the health system, e.g. [services for] ... people with serious mental illness and homeless Australians.”



In addition, the Agreement provides that LHNs will engage with local primary health care providers, and Medicare Locals.

The Agreement also states that [Medicare Locals] and LHNs will be expected to have some common membership of governance structures where possible; that “[Medicare Locals’] service contracts will require [Medicare Locals] and LHNs to work closely together”, and “[Medicare Locals] will establish a formal engagement protocol with local LHNs”.

It should be noted also that under the Agreement, the Commonwealth and States commit to undertaking further work to consider specialist community mental health services, for people with severe mental illness, either for transfer to the Commonwealth or for strong national reform efforts with current roles and responsibilities, with the outcomes of this work to included as part of the overall mental health report back to COAG in 2011.

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

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

Question no: 59

OUTCOME 13 Acute Care

Topic: HEALTH REFORM

Hansard Page: F&PA15

Senator Cameron asked:

Can you outline the current situation with emergency department waiting times, and how many people wait longer than four hours?

Answer:

According to the *National Healthcare Agreement: Baseline performance report for 2008-09*, published by the COAG Reform Council on 30 April 2010, during 2007-08, 67 per cent of patients treated in larger public hospitals were seen within recommended times according to the triage scale of clinical urgency—but 100 per cent of the most urgent presentations were treated on time in all jurisdictions.

Other data from the 2007-08 National Non-Admitted Patient Emergency Department collection indicate there were over 1.7 million emergency department presentations in larger public hospitals, where the total time between arrival and physical departure from the emergency department was longer than four hours. This represents over one third of all unplanned presentations to emergency departments. (This excludes patients who did not wait to be attended by a health care professional or who were dead on arrival. Presentations with missing or invalid waiting times data have also been excluded.)

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

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

Question no: 60

OUTCOME 5: Primary Care

Topic: HEALTH REFORM

Hansard Page: F&PA31

Senator Siewert asked:

There are also grandfathering arrangements built into the proposal, which are over a three to four year period. I can get back to you with precise details of that.

Answer:

Grandfathering arrangements will be available for the first three years of the new arrangements (1 January 2012 - 31 December 2014) to ensure that practices are not disadvantaged by the restructure of the Practice Incentive Program and Medical Benefits Schedule practice nurse arrangements in the short term. Grandfathering arrangements will be available to any practices that are disadvantaged under the new arrangements.