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Governance and structural reforms: shifting responsibility and resource allocation for better health

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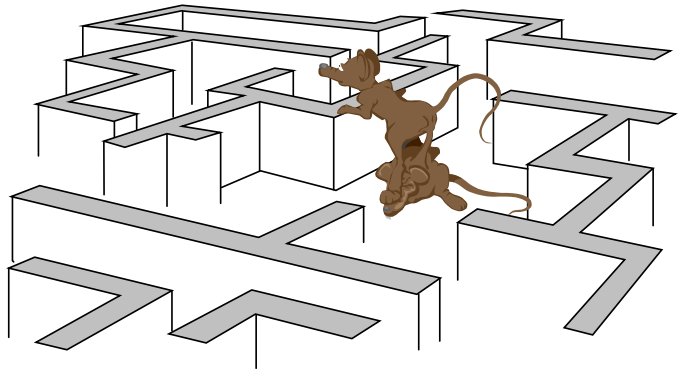
The Issues to be Considered

- General principles and requirements
- Comments on alignment of funding and governance in the NHHRC Interim Report



General principles and requirements

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What we need regardless of the option

- A national health charter
- National policy and planning
- National health intelligence and information
- National regulation
- Regional planning and delivery
- Strengthen primary health care and improve the integration of 'health' and 'aged' care
- Recognise that change is a process

Dwyer J and Eagar K (2008) Options for reform of Commonwealth and State governance responsibilities for the Australian health system. NHHRC discussion paper

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Six Design Principles

- Only fix what's broken
- Enact national leadership
- The system must be designed as a system, with coherent roles, authorities and accountabilities
- All service integration is local
- Accountability for funding and commissioning health care is just as important as accountability for providing care
- Maintain the universality of Medicare

Dwyer J and Eagar K (2008) Options for reform of Commonwealth and State governance responsibilities for the Australian health system. NHHRC discussion paper

System design is not a set of free choices

- The design of national health systems is not a single problem with a single right answer.
- Elements must be aligned: policies, funding arrangements, skills, roles and accountabilities come as packages:
  - we need change precisely because of the current lack of such alignment.

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Leutz Laws of Service Integration

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

Selective comments on alignment of funding and governance in the NHHRC Interim Report

The devil is in the detail

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Governance and funding reforms in the interim report

- The devil is in the detail, including:
  - Chap 2 - primary health care
  - Chap 8 - Aboriginal and Torres Strait Islander health
  - Chap 9 - remote and rural health
  - Chap 11 - oral health
  - Chap 12 - governance options
- Mixed funding
  - fee for service (FFS), case payments, capitation, pay for performance (P4P), regional grants, other grants
  - not necessarily aligned to governance and management

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Option A Shared responsibility with clearer accountability

- Retain role for both Commonwealth and state and but change responsibilities. Commonwealth:
  - responsible for all primary health care funding and policy
    - including community health ($4 billion of state $ to transfer to Commonwealth)
  - pay states and territories using casemix for inpatient, emergency department and hospital outpatient treatments
  - report is silent on how community health would be managed under this option

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Option B. Commonwealth

- Commonwealth solely responsible for public health care, delivered through regional statutory health authorities (RHAs).
  - The way universities are funded
- RHAs responsible for managing hospitals and community health in parallel to continued national programs
  - provision for states and territories to become the RHA
- States would transfer $24 billion (existing state health $) to the Commonwealth

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Option C. Social insurance

- Compulsory social insurance to fund local delivery.
  - tax-funded community insurance scheme
  - instead of Medicare, multiple, competing health plans for people to choose from, which would be required to cover a mandatory set of services including hospital, medical, pharmaceutical, allied health and aged care
- Report is silent on how hospitals and community health are managed under this option
- Report is also silent on how geographic equity would be achieved

Aboriginal and Torres Strait Islander

- National Aboriginal and Torres Strait Islander Health Authority
  - purchaser as per DVA for those who register
  - from accredited providers
    - Community Controlled, mainstream services and hospitals (presumably all accredited?)
  - contracts with community controlled services
  - direct billing (FFS) for other services
    - presumably case payments for hospitals?
  - essentially, NATSIHA is the health plan in Option C

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Rural and remote

- Population needs-based funding
  - Who holds the funds under the 3 options?
  - Presumably excludes those who register with the National Aboriginal and Torres Strait Islander Health Authority?
- Expand multi-purpose services to populations of 12,000
  - auspice body under the 3 options?

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Primary care

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- Principal of equity in provision of PHC funding
  - but inconsistent proposals elsewhere about how this would be achieved
- C'wealth funds community health (CH)
  - Option A - silent on how CH is managed
    - 30,000+ salaried community health staff across Australia
    - what about hospital-managed CH?
    - definition of primary care includes community mental health
      - but hospital-based mental health stays with the states in Option A
  - Option B - managed by regional statutory authority

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Primary health care (2)

- Divisions of PHC
  - 'health stewardship' and local planning, but not health service management
- 'Comprehensive PHC Centres'
  - offer initial fixed capital grants on a competitive basis
    - private for profit and NGO?
  - assume that many CH staff would move to these?
- GPs
  - mixed payments - FFS (including for prevention), grant funding for enrolment, P4P

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Three elephants in the room

- Hospitals
  - how to manage them
  - how to better manage demand
- Health insurance
- The fact that capped systems (eg, public hospitals) have incentives to act in ways which are fundamentally different to systems (eg, FFS) that are uncapped
  - NHHRC proposals mostly do not align the incentives

If we don't fix these 3, we can't fix the health system!