Position Statement

A national health and hospitals network for Australia’s future

Preamble
The Australasian College of Health Service Management (the College) is the professional association for health service executives and managers, in both clinical and non-clinical leadership and management roles. The College has over 3000 members nationally and is the largest body representing multi-disciplinary health managers in Australia.

On 3 March 2010 the Prime Minister the Hon Kevin Rudd MP released the paper A National Health And Hospitals Network For Australia’s Future (NHHN) which outlines the government’s proposals for the reform of government funded health services in Australia.

This paper outlines the position of the College on the NHHN. The Board of the College believes it represents the view of the majority of the members and fellows of the College. As with all professional bodies, the College has a diverse range of members and fellows and not all members will agree with all the views expressed in this paper.

Summary of the College’s position
The College agrees that our current health system is fragmented and that blurring of responsibilities between the state and federal governments results in cost shifting, inefficiencies and blame-shifting. Whilst the College supports the intent of the reform in addressing these issues, the devil is, as always, in the detail, much of which is still being developed.

The College accepts the fundamental arguments that the continued cost increases in the provision of public health care services will mean that state and territory governments will not be able to fund public hospital services, in the foreseeable future. The College agrees that reform is required and that the current financial arrangements between the state and territory governments and the Australian Government in relation to health care must change.

While supportive of the goal of improved integration of primary health care services to respond to the increasing demand from the Australian population for care of chronic disease, the current proposals provide insufficient details to enable the College to support this proposal as it stands. Changed funding arrangements will inevitably lead to changed governance and management arrangements for local primary health care services and these are not detailed in the NHHN.

The College supports the proposed decentralisation of administration of hospital service and the establishment of smaller groupings of hospitals with local governance and management structures. However, the College believes that the existing international evidence would suggest that organising the health system in response to population needs is a more effective approach for the
establishment of networks than simply determining grouping based on the number of hospitals. This approach also supports strong linkages of the Hospital Networks with the Primary Health Care system and these linkages are not developed in the NHHN.

The College supports the principle of locally established governing councils and chief executive officers where the appointment and dismissal of council members and chief executives is shielded from the political process. Council members should be selected on skill and qualifications. Chief executive officers should be selected on the basis of appropriate qualification in health services management and experience, and with a commitment to continuous professional development for themselves, their management staff and their council members. The Australian Government, together with state and territory governments should undertake workforce planning for future health services managers and establish a national training scheme for health services managers.

The College accepts the proposal to fund the Local Hospital Networks with an activity based costing mechanism. However, the College will need to see more details before endorsing the concept of an ‘efficient price’.

The College is concerned that the proposals, as outlined, do not shift responsibility clearly to one level of government and there is continued scope for cost shifting and blaming.

The government’s proposal
The government is proposing major structural changes that, in summary, will mean that the federal government:

- becomes the majority funder of public hospitals;
- take over all funding and policy responsibility for GP and primary health care services;
- dedicate around one third of annual Goods and Services Tax (GST) allocations currently directed to state and territory governments to fund this change in responsibilities for the health system;
- change the way hospitals are run, taking control from central bureaucracies and handing it to Local Hospital Networks; and
- change the way hospitals are funded, by paying Local Hospital Networks directly for each hospital service they provide, rather than by a block grant from the Commonwealth to the states. (Australian Government, 2010, p. 1)

The College’s position in relation to these proposals

Federal government becoming the major funder of public hospitals using one third of GST payments

The College broadly accepts this proposal.

State and Territory governments currently rely on the grants they receive from the Federal Government for a significant component of the funding they need to operate their public hospitals. The Howard government’s decision in 1998 to allocate the revenue collected by the Goods and
Services Tax (GST) to the states and territories to replace the previous funding they received. The GST revenue now forms a significant contribution to the funds available for public hospital budgets. However, Eccleston (2008), in discussing the vertical fiscal imbalance between the Federal and State and territory governments, argues convincingly that the cost increase of public hospitals borne by state and territory governments will exceed the increase in the share of GST revenue that is allocated to the states. He argues that this inflationary imbalance will increasingly lead to a situation where the states and territories will no longer be able to afford the cost of public hospitals. This argument forms the basis of the Australian Government’s rationale that it is best placed to meet the future increasing costs of public hospital in Australia.

The College accepts this argument.

The federal government assumes funding and policy responsibility for general practitioner and primary health care services

The current proposals provide insufficient details to enable the College to support this proposal.

The proposal is that general practitioner services, community health services and ‘primary care like’ services currently provided by hospitals on an outpatient basis will, in future, be funded solely by the federal government. The paper makes reference to the goal of allocative efficiency. The proposal also implies that, by some mechanism as yet to be described by the government, these services are integrated in a manner that improves access to and quality of care. The College agrees with the goal that primary care services should be more integrated. However, before it can support these high level concepts the College will require further detailed understanding of the new organisational, governance and management arrangements that will be implemented to achieve them.

The new funding mechanisms will in a number of cases, require new management and reporting relationships, but the plan does not discuss this issue, other than to make reference that some agreements may continue, such as that with South Australia over the funding and management of the GP Plus clinics. There is a suggestion that some states may wish to continue to operate services, but is silent on how the integration and allocative efficiency goals would be achieved if this were to occur. The paper does acknowledge that states may wish to divest themselves of operational control, but is silent on what would replace the current arrangements.

The evidence base for the success in Australia of the structural arrangements given as examples in the paper is weak. There are few examples of structurally integrated general practitioner and community health care services in Australia to generate confidence that a universal strategy of this nature will be successful. The NHHN makes reference to the South Australian GP Plus initiatives and the Australian Government’s planned 36 GP Super Clinics as examples of the type of model for integrated primary health care. Many of these facilities have yet to be built and commence operation.

While the College is supportive of the overall objective of an integrated primary health care sector it recognises significant differences in the manner in which general practice operate from other ambulatory and community based health services and these differences will need to be taken into
consideration in any new organisational model. The notion of ‘integration’ in the Government’s plan appears to be accepted without the need for explanation. However, there are challenges related to integration and these have been pointed out by authors such as Leutz (Leutz, 2005). Leutz articulates five ‘laws’ around the idea of integrated medical and community based services. Two of his arguments are central to the College’s concerns regarding the lack of detail in the government’s proposal around organisational arrangements. These are that integrating some services together creates disintegration with other services, and secondly, some services are sufficiently different in nature and orientation that successfully integration is unlikely.

The College also recognises the difference between ‘co-location’ and ‘integration’. Placing different services in the one (new) building as outlined by the Government’s Super Clinic initiative does not automatically achieve integration of service delivery, particularly if the states and territories maintain employment, management and clinical governance responsibilities.

The challenges the College recognises and would like to see addressed prior to providing its full support to this initiative are the following:

- The models cited in the paper (GP Plus and GP Super Clinics) are new, intended to meet needs in specific areas (such as outer metropolitan or regional locations) and have not been tested as the model for the broader community, particularly those is urban locations, well supplied with general practitioner services, where the bulk of the Australian population lives.
- Co-locating and integrating all primary care services, as suggested in the examples cited in the NHHN (GP Plus and Super Clinics), raise significant management and culture challenges. General practitioners currently operate primarily as independent professionals or in partnerships with other medical practitioners (with a small number of corporations operating in the sector). Community health services and other community care services are generally provided by staff employed on a salaried basis by government authorities or not-for-profit organisations within a hierarchical organisational model. These two organisational models will provide challenges for an integrated service. Of particular concern are the future clinical governance arrangements for the wide variety of community based health services that are to be integrated with general practice and, through changed funding arrangements, uncoupled from their existing governance and management structures currently built around hospitals and/or regional health/ community care authorities in a number of states and territories.
- General medical practice is oriented toward services that are renumerated primarily on a fee for service basis paid from an uncapped budget (MBS) and the NHHN paper provides assurance that this arrangement will not change. Community health services are generally funded within fixed grants. These different funding mechanisms create potentially conflicting incentives.
- The assumption in the paper is that general practitioner and community health services are natural ‘integrators’. While the plan makes reference to other community based services such as those funded through the Home and Community Care Program and the Aged Care Program, it is silent on how integration with services provided by these programs will be impacted. In many instances there is a closer association between some community health services and these other community based services than with general medical practitioners.
The NHHN does not address equity and access issues and how these will be managed within the new organisational arrangements that may flow from a new funding model. Professionals employed in community health services provide care to large caseloads. Their clients and patients have general practitioners from a number of different medical practices. The document is silent on how community health professionals co-located with one general medical practice will deal with competing demands for service from the patients of general medical practices to whom they are not ‘attached’. There is a risk, in the models cited as examples, that patients of general practitioners operating from a ‘Super Clinic’ in an urban setting where there are multiple general practitioners, may get preferable access to care from community health staff over the patients of general medical practitioners who are not part of the ‘integrated’ team?

The NHHN argues in favour of ‘horizontal integration’ (integrating ambulatory and home based services) rather than ‘vertical integration’ (integrating ambulatory and home based services with institutional based services). However many community health services, particularly mental health services and some aged care, are currently vertically integrated with inpatient units creating specialist teams that can provide services in a range of settings.

While focusing integrated primary health care around people with chronic care in the community addresses this increasing demand, not all community health services are focused around clients and patients who need to access primary medical care frequently. Early childhood services are examples of community services that focused on wellness rather than illness and may be inappropriately integrated into teams based around chronic care.

The College requires more information on the future funding and management arrangements for primary health care and community health services before it can support this proposal.

Local Hospital Networks to run hospitals

The College broadly supports the dismantling of the current governance and management of hospital services in those states where there is a high degree of centralisation.

The NHHN paper proposes that state and territory governments establish Local Hospital Networks, of fewer than four hospitals governed by a ‘Council’ appointed by these governments and managed by a chief executive officer. The intent of this initiative is to return control of local public hospitals to local communities.

The Colleges agrees with the view expressed in the NHHH paper that clinicians and the local community often feel frustrated with their incapacity to influence decision making affecting the operations of local services under the arrangement that exist in some states. The College also shares the frustrations expressed by many health services managers who struggle with decisions made by administrators with whom they have little contact or influence. The College also notes the findings of the Garling enquiry into acute health services in NSW which found that hospital general managers are no longer we able to make relatively minor management decisions within the current structure of Area Health Services.
While supportive of the concept of more local input into decision making affecting local hospitals, the College is concerned that the lessons learned previously, about the administration of public hospitals by independent boards, are taken into consideration by state, territory and the Australian governments in establishing new governance and management structures. In particular, the evidence is clear of the need to establish meaningful targets for population health, and not just system efficiency, with investment in information management and technology to support these governance and management structures.

Size of the proposed Local Hospital Networks

Significant operational efficiency has been achieved within the public hospital system by a number of states and territories over the past couple of decades in the administration of some hospital processes and support services. This has been achieved, in a number of examples, through regional administrations of medium to large numbers of hospitals and health services. Rationalisation of information technology, food services, laundry, finance, pathology and diagnostics, procurement and other administrative functions have been achieved by establishing shared services, centralising some activities and processes where it is appropriate to do so, and reducing duplication. Networking of clinical services across a number of hospitals has been made possible within regional authorities and has improved the quality of patient care and clinical governance processes. In a number of cases these efficiencies and improvements in quality have only be achieved because of relatively large groupings of hospitals within a single district, area or regional arrangement.

The College does not support the suggestion that the Local Hospital Networks consist of only a small number of hospitals. The NHHN suggests the Local Hospital Networks should be between one and four hospitals. The College believes that this small number of hospitals may not be sufficient in size to achieve efficiency in some hospital operations and maintain quality in some clinical services. Rather than basing the size of a network on the number of hospitals it may be better to specify criteria for the establishment of networks based on shared catchments, total volume of service and size of resources needed for efficient operations, as well as the boundaries for primary health care services, and other key agencies such as local councils.

There is strong international evidence on the effectiveness of a population health approach to health system planning. By adopting this approach the government would organise service delivery around the needs of an identified population rather than basing the planning framework on a consolidation of existing physical resources.

Administration of public hospitals by local governing councils

Most states and territories, in the past, appointed boards to manage public hospitals. Administrative reforms over the past two decades have resulted in a number of states removing hospital boards altogether. Some states, like Victoria, continue to appoint boards to govern local hospitals. The decisions by many state governments to remove boards from the management of public hospitals were made at different times and for different reasons. However the collective experience from these previous arrangements can be summarised in the following points:

- Many hospital boards, particularly in rural and regional locations, struggled to attract members with the broad range of skills needed to govern multimillion dollar enterprises.
Conflicts of interest arose where clinicians are appointed to the board that governs the hospital in which they have clinical appointments.

Local boards often developed parochial views on the role of their hospital that were inconsistent with operational efficiency goals and establishing clinical services that meet quality standards related to volume and complexity.

Board appointments often became political process, where decisions were taken away from the relevant departments and made within the office of the responsible Minister, with the effect that board members were appointed primarily on their political sympathies rather than their expertise.

Local hospital boards can become ‘institution focused’ rather than population focused, and concentrate on pursing policies that are in the interests of the organisation rather than the population its serves.

Legislation subjected the boards to the control and direction of the minister, which often limited their decision making capacity even where the decisions they wished to make were in the best interest of the individual hospital and the patients they served.

There are some decisions that are in the best interests of the community but not in the best interests of an individual hospital, or clinical team; and it is difficult for the board of an individual facility to make those decisions.

With these limitations in mind the College supports the recommendation of the appointment of professional governing councils and chief executive officer who will be responsible for the governance and management of the Local Hospital Networks. The College will support specific proposals for the establishment of local governing councils if the enabling state/territory legislations enshrine the following principles:

- Appointment of members to the local governing councils should be segregated from the political process
- Strict process should ensure that conflicts of interest are avoided
- Appointments to governing councils should be restricted to individuals who can demonstrate minimum skills and knowledge and competency in the governance of large complex organisations; representation of the needs of the population be achieved through more effective mechanisms than council appointment
- The legislations which establishes the hospital networks should enshrine a clear separation of the roles of governance and management
- The councils will be free to appoint and to dismiss the chief executive officer based on agreed performance criteria without political interference
- Council members and the chief executive officer must commit to performance appraisal and continuing professional development to maintain their membership of the council
- Councils should be required to adhere to the principles of corporate governance outlined by the Australian Stock Exchange (Australian Securities and Exchange, 2007) (or other suitable code) and to subject their council processes to independent quality assessment
- Councils should be required to ensure that the hospitals under their administration achieve and maintain accreditation with an appropriate standards body.
The College will support the passage of legislation that enables councils to appoint chief executive officers provided that legislation reflects the principles for the training and appointment of health services managers outlined in the SHAPE declaration (Briggs, 2008). In summary, the legislation should enshrine the following principles:

- Chief executive officers should only be appointed where they have appropriate qualifications, skills and experience in managing health services.
- Consistent with professional regulation, the preferred qualifications of chief executive officers are outlined by an appropriate professional body.
- Chief executive officers should demonstrate a commitment to continuous professional development and improvement.
- Chief executive officers should be free of Council, departmental and political interference to appoint managers and staff, subject to accepted industrial practice and guidelines.
- Chief executive officers should be accountable for ensuring their system managers have appropriate qualifications, skills and experience in managing health services. There is strong evidence that the current system has many managers in place without the requisite management competencies.

The College also strongly recommends that the Australian government, as the principle funder of health services, in association with state or territories, undertake workforce planning to ensure the supply of a cohort of future managers with the necessary skills to manage health services in the future. Consideration should be given to a national program of health services manager education and training through selected supervised placements for aspiring and new managers.

**Local Hospital Networks are paid directly for each hospital service they provide by the Federal government**

The College broadly supports the proposal to fund hospitals on an activity basis; presumably through a casemix basis, using DRGs as the payment mechanism of choice.

The College has some reservations with the ‘one size fits all’ approach that the NHHN implies for all hospitals across Australia and the concept of the ‘efficient price’. The College is also concerned that the roles of Local Hospital Networks, state/territory and Australian governments, as outlined, will not put an end to cost shifting and ‘blaming’, and believes that there may be serious consequences for the future of the public health system if there is not a role for state and territory governments that is acceptable to them.

Diagnosis Related Groups (DRGs) as a casemix method for classifying acute inpatient episodes is well established and accepted in Australia. The current DRG version used in Australia – AN-DRG (version 6.0) – has been produced by the Australian Department of Health and Ageing. Casemix as a mechanism for determining payments for acute hospitals has been in place in some states, such as Victoria and South Australia, for many years. Provided that the payment system takes allowance to the limitation with the use of DRGs for some types of acute hospital admissions then this system of payments is supported.
Prior to accepting this proposal in full, the College would like to see more information on the proposal to establish the concept of ‘efficient price’, and how allowances will be made in the payment system for hospitals that face higher costs than the majority of hospital in Australia.

The role of the states and territories in managing acute hospitals

The NHHN outlines a much reduced role for state and territory governments. They will retain ownership of the hospitals, establish a legislative framework for the establishment and management of the Local Hospital Networks, will retain responsibility for staffing and industrial relations, have a continuing responsibility for health services planning and capital development and provide 40% of funding of recurrent and capital costs. However, with the Australian Government paying Local Hospital Networks directly, state and territory governments will be limited in their control over service mix, access and volume of services. The shared responsibility for funding, and more importantly, the maintenance of different silos for funds (primary care, aged care, acute care), will continue to provide scope for cost shifting between primary and acute services, and acute and aged care services, and continue to provide the opportunity for blaming of other governments.

The College is also concerned with the divided accountability of the Local Hospital Networks who will have separate (and presumably different) reporting responsibilities to two levels of government. Establishing clear lines of accountability will be essential to the success of the reformed health system.

National standards

The College supports the development of national standards, and recognises that increased consistency and transparency will enhance managerial and clinical accountability to their funders and the patients they serve.

The College is encouraged that, in addition to a standards framework for access to elective surgery and emergency departments, there will also be standards for access to local GPs and other health professionals. The College asks that this also includes measures of inequities of access.

Conclusion

The College agrees that strong action is needed to fix the problems with the public health care system, however whilst the College acknowledges the need for change, there are significant gaps in the NHHN which need to be clarified before it can give its full support to the Government’s proposals.

The College believes that effective implementation of this plan will require strong leadership and management from managers and clinicians in the health system. The Australian Government, together with state and territory governments should undertake workforce planning for future health services managers and establish a national training scheme for health services managers.

The Australasian College of Health Service Management, as the only multi-disciplinary College for health executives and managers requests an invitation to participate in taking forward the reform
agenda, Change is required and the College is open and willing to contribute to the development and implementation of a workable reform package to support managers and clinicians in delivering the highest quality and most efficient healthcare possible.

Contacting the College

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This paper has been prepared by Richard Baldwin, Board Member, Australasian College of Health Service Management on behalf of the Board and with input from board members, College staff and members.

