

29 April 2010

National Health Reform Update Bulletin 2

This is the second in a series of bulletins AGPN is producing to keep Network members up to date on progress with the National Health Reform agenda. This update (Update 2) provides an overview of the Prime Minister's further recent announcements of relevance to the Network and primary health care (PHC). It also includes a short analysis of the Council of Australian Governments' (COAG) National Health and Hospitals Network (NHHN) Agreement as well as any implications and next steps for the Network arising from this.

A snapshot of key developments in health reform policy work to date covering government and external reviews as well as policy work developed by AGPN, is provided separately in Factsheet 1.

A short update on AGPN's work to support the Network through the proposed reforms, including transition to primary health care organisations (PHCOs) is also provided separately at Factsheet 2.

Current Situation **Government announcements**

On 12 April 2010, the Prime Minister announced the establishment of primary health care organisations (PHCOs). This followed various other key announcements on health reform forthcoming during the past five weeks (see Factsheet 1), including the initial declaration on 3 March of the establishment of the National Health and Hospital Network (NHHN). Key aspects of the proposed NHHN included the development of Local Hospital Networks (LHNs) and the federal takeover of:

- 60% of the efficient costs of public hospitals and
 - all policy and funding responsibility for PHC
- in a newly structured, nationally funded, locally run health system. A comprehensive overview of this announcement was provided in AGPN's previous reform update in March available from: http://www.agpn.com.au/__data/assets/pdf_file/0003/23952/20100324_br ReformAgendaUpdate-March-2010FINAL.pdf

The 12 April announcement provided more detail about the PHC aspects of the NHHN, outlining the establishment of primary health care organisations (PHCOs) across Australia. The objective of PHCOs as outlined in the announcement is to support GPs and other health professionals improve the delivery of PHC services at the local level. PHCOs as announced will:

- complement services currently provided by GPs, particularly around chronic disease care, including facilitating allied health and other support for people with chronic conditions, as identified in GP care plans
- work collaboratively with local health care professionals to better coordinate care and to ensure that patients can easily and conveniently access the full range of services they need
- work closely with LHNs to provide more seamless care, including assisting with patients' transition out of hospital and, where relevant, into aged care
- play an increasing role, over time, in delivering PHC services currently funded by states but proposed to transfer to the Commonwealth in future as part of the NHHN
- play a particular role in targeting PHC services to respond to service gaps by identifying groups of people missing out on GP and PHC and/or identifying specific services required in a local area to address unmet needs
- deliver health promotion and preventative health programs targeted to risk factors in their local communities.

The announcement did not specify PHCO numbers but clearly states that the first PHCOs will be established by July 2011, with all PHCOs established by July 2012.

The announcement also foreshadowed that funding arrangements to support primary health care organisations will be included in the May 2010 Federal Budget.

This announcement is largely in line with the role and functioning of PHCOs that AGPN outlined in *Connecting Care*: a blueprint for PHCOs in November 2009 developed in consultation with the Network. It also builds directly on recommendations from the National Health and Hospital Reform Commission (NHHRC) report and is consistent with key policies in AGPN's PHC Position Statement (released in February 2009).

Council of Australian Governments (COAG)

A meeting of the Council of Australian Governments (COAG) to negotiate a national health reform agreement occurred on 19-20 April. The negotiations included a federal takeover of policy and funding responsibility for all GP and PHC services, including those currently state run.

Outcomes from these meetings indicated that all states except WA agreed that the Commonwealth would become the dominant (60 per cent efficient costs) funder of Australian hospitals. COAG also agreed that:

"The Commonwealth will have full funding and policy responsibility for GP and primary health care, as defined in the National Health and Hospitals Network Agreement, including community health centres, primary mental health care, immunisation, and cancer screening programs"

and that *"The Commonwealth will build on its responsibility for general practice and primary health care with the introduction of primary health care organisations. These bodies will be responsible for improving integration of services and reducing access gaps so that their local community can access care that meets local needs."*

The full Communiqué is available at: http://www.coag.gov.au/coag_meeting_outcomes/2010-04-19/docs/Communique_20_April_2010.pdf

More specific detail from the COAG meeting about the agreed roles and responsibilities of the Commonwealth and State governments regarding the NHHN was released 22 April 2010. The National Health and Hospitals Network Agreement covers general state/Commonwealth arrangements for public hospitals, LHNs and PHCOs including financing, the proposed performance and accountability framework and national governance.

The full COAG NHHN Agreement document is available at: http://www.coag.gov.au/coag_meeting_outcomes/2010-04-19/docs/NHHN_Agreement.pdf PHC and PHCOs are primarily discussed in schedule B of this document.

A major decision reflected in the Agreement is that the Commonwealth will take full funding and policy responsibility for Australia's GP and PHC services from July 2011 as agreed in Schedule B. This covers the majority of PHC services, including many currently run by the states which will be transferred over to the Commonwealth 1 July 2011. The specific areas of Commonwealth responsibility are as follows:

- community health centre (CHC) primary health care services, such as generalist counselling, integrated care, GP and primary care coordination programs, including Indigenous and rural and remote primary health care services;
- primary mental health care services which target the more common mild to moderate mental illnesses;
- hospital avoidance programs that do not relate specifically to patients who are predominantly being treated in acute care;
- primary and secondary prevention programs for early intervention and care coordination that focus on the management of patients with chronic disease in the community;
- screening programs for cancer delivered in a primary health care setting;

- immunisation¹; and
- any further services to be agreed between the Commonwealth and one or more of the States.

States will continue to have policy and funding responsibility for the following services, at least until 5 years from 1 July 2011, which have been agreed to be excluded from the transfer to Commonwealth:

- ambulance services;
- existing public dental services;
- health care for prisoners;
- school and workplace primary care programs;
- hospital avoidance programs that relate more specifically to patients who are predominantly being treated in acute care; and
- specialist sexually transmitted infection services and general sexual health services.

Primary Health Care Organisations PHCOs

PHCOs will be established across Australia with the first to be operational by mid 2011. (See schedule B page 23) and all others established by July 2012. The final number and boundaries of PHCOs will be bilaterally agreed, where possible consistent with LHN boundaries, by 31 December 2010. PHCO structures and boundaries may however continue to evolve beyond this date. The Commonwealth will continue to consult with the States on any changes made.

PHCOs will be integral to delivering the NHHN, in partnership with the LHNs and will be responsible for delivering better integrated and responsive local GP and primary health care services to meet the needs and priorities of patients and communities.

PHCOs will be subject to a service contract agreed with the Commonwealth in consultation with the relevant state or territory and other relevant stakeholders/health professionals. Service contracts will require PHCOs and LHNs to work closely together including PHCOs establishing a formal engagement protocol with local LHNs.

PHCOs will be independent legal entities and will operate with strong local governance (including broad community and health professional representation, as well as business and management expertise). Strong clinical leadership will be a key feature. PHCOs and LHNs will be expected to have some common membership of governance structures.

PHCOs will have strong links to local communities, health professionals and service providers, including GPs, allied health professionals and Aboriginal Medical Services. The Commonwealth and State governments will also work together to create linkages and coordination mechanisms between PHCOs and other State services that interact with the health system, e.g. children at risk, people with serious mental illness and homeless Australians.

As is in place for the Network now, PHCOs will operate under agreed performance monitoring and reporting requirements. (See Schedule D for the Performance and Accountability Framework and schedule E for the governance arrangements for that framework). States will have opportunities to contribute and access information on the outcomes of the performance arrangements.

State governments will not establish duplicate GP and PHC organisations. Where they already exist they will become part of arrangements for PHCOs as part of the transfer of responsibility for funding of primary care outlined previously.

Responsibilities of Primary Health Care Organisations

COAG agreed that PHCOs' main functions were as stated in the Prime Minister's announcement on the 12 April with a focus on

- Better coordinating and integrating care, including facilitating access to the full range of PHC services people need, especially for those with chronic disease.
- Targeting areas of unmet service need and facilitating access to services to fill these service gaps
- Working with LHNs on care pathways, hospital avoidance programs and transitions out of hospital and/or to aged care
- Delivering health promotion and preventive health programs targeted to risk factors in communities, in cooperation with the National Preventive Health Agency, once it is established
- Undertaking population level planning and potential fund-holding roles as needed in areas of market failure and where patient needs are not being met.

Home and Community Care (HACC) related programs

These will be restructured to ensure a more consistent and unified aged care system covering aged care through to residential care. In essence:

- The States will assume responsibility for funding and regulating basic community care services currently delivered under HACC for people under the age of 65 (under 50 for Indigenous Australians) including packed care services, and
- The Commonwealth will assume funding and program responsibility for these services for people 65 years or over (50 years and over for Indigenous Australians). The Commonwealth will also assume funding responsibility for specialist disability services provided under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians).

Changes and responsibilities relevant to HACC do not apply to Victoria.

Future considerations for healthcare transitions:

COAG agreed to consider further either the transfer to Commonwealth responsibility or strong national reform around roles and responsibilities for the following 5 services:

1. community health promotion and population health programs including preventive health
2. drug and alcohol treatment services
3. child and maternal health services
4. community palliative care
5. specialist community mental health services, for people with severe mental illness

There was agreement to put a recommendation to COAG in December 2010 regarding the first 4 items above and to include 5 above in the overall report back to COAG on mental health in 2011.

Funding for the expanded Commonwealth responsibilities of 60 per cent of hospital funding and 100 per cent of GP and PHC will be provided for by a proportion of the GST which will be fixed from 2014 – 2015, based on the previous year costs and indexed at the rate of overall GST growth.

The Commonwealth will establish a National Funding Authority (NFA), to be established from 1 July 2011 as an Independent Commonwealth statutory authority to oversee a NHHN Fund and the distribution of the Commonwealth funding contribution through this mechanism. Governance of this body will include at least one member having regional and rural expertise.

Next steps and implications for the Network

The COAG Agreement provides a welcome confirmation that PHCOs will go ahead and much of what is proposed is in line with AGPN's Blueprint for PHCOs. AGPN is seeking clarification however as to the extent of the funding and planning roles proposed for PHCOs. These are currently ambiguous in the document. If PHCOs are to have the authority required to shift the emphasis in the health care system more onto PHC, then PHCOs must be given sufficient capacity to perform these roles.

Timing for transitions have also been agreed. The first PHCOs will be established by July 2011 with the remaining PHCOs established by July 2012. The Prime Minister's 12 April announcement states that PHCOs will be built from the existing Network of Divisions of General Practice in order to avoid additional bureaucracy. There is an imperative for the Network to be ready to transition. AGPN is continuing to progress its work with KPMG on a transition plan for the Network to PHCOs. This work will provide significant support around this process. PHCOs and LHNs will also be encouraged to have common geographic boundaries where possible. This has also been taken into account into the boundary planning work that AGPN has commissioned Cranny and Associates to develop. (See fact sheet 2 for further details on these two consultancies.)

The COAG document talks of at least a 5 year plan for states to continue with delivery of certain PHC functions after which it is possible that these PHC functions will also transfer over to PHCOs. Again this is consistent with the KPMG transition plan that is currently under development whereby a 5 to 10 year outlook is envisaged before PHCOs reach full capacity and operations.

Although the timeline for transfer of all functions will be staged, the fact that PHCO boundaries will be a matter for the Commonwealth to resolve by 31 December 2010 may have some impact on the transition of the first tranche of PHCOs by 1 July 2011. AGPN will seek clarification around this in order to best prepare the Network for transition.

The COAG agreement also shows that a state presence in PHC will continue to be important, initially for some of the PHC services retained by the states but also in the longer term in relation to the LHN-PHCO interface and the role that states will play in contributing to health policy development.

Main points to note:

The main points for the Network to be aware of are:

- Authority: it is not clear if PHCOs will fundhold for a number of universal programs and services other than in circumstances where there is market failure. It is not clear (it is certainly not highlighted in the COAG document) if PHCOs will perform the regional level health planning that we envisaged.
- Governance: PHCOs will be required to have some shared membership and governance with Local Hospital Networks (LHNs) and to work closely with them - as well as with other stakeholders.
- State role: there is still a significant role for the states. They will retain certain PHC functions for the next 5 years, including policy input. There could be an ongoing role beyond that too in relation to the LHN-PHCO interface. This is a consideration for the structure of the PHCO network with regard to the roles, functions and configuration of the proposed national PHCO organisation.
- Boundaries and timing: Local hospital network (LHN) and PHCO boundaries will ideally align where possible. The first PHCOs will be established by 1 July 2011, with the remaining ones established by 1 July 2012. However, final boundaries will not be determined bilaterally between governments until 31 December 2010. This could put the early adopter PHCOs under significant pressure.