

PUTTING HEALTH IN LOCAL HANDS: SHIFTING GOVERNANCE AND FUNDING TO REGIONAL HEALTH ORGANISATIONS

By Tim Woodruff, Fiona Armstrong, David Legge, and Rod Wilson

DISCUSSION PAPER

CENTRE FOR POLICY DEVELOPMENT

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Main Points

Australia's unique geography and federal governance model has, over time, led to a health care system that is unnecessarily fragmented, inequitable and inefficient. By shifting health care governance and funding to regional agencies that are more responsive to the needs of local communities we could dramatically improve both the fairness and effectiveness of Australian health care.

Access to health care services in Australia often reflects the inverse care law: 'those who need the most health services receive the least, and those who need the least receive the most'.¹

The reforms recommended by the National Health and Hospitals Reform Commission in its final report will not be enough to solve these problems. Some will further entrench existing inequities and inefficiencies. For example:

- the Commission's approach to primary care does not address the need for integration with other services, including hospital care, aged care, and the proposed expansion of subacute care;
- the proposed Medicare Select model has very limited or perhaps no capacity to redistribute funds to areas of increased need and workforce shortage - funds would continue to follow the provider; and
- the recommendation for a needs-based increase to funding for rural and remote areas fails to explain why needs-based funding should not apply in all areas.

The authors of this paper propose the establishment of local Regional Health Organisations (RHOs) across Australia, with each responsible for the health care needs of a defined population within its region. The RHO governance and funding model would improve the provision of health care by:

- shifting responsibility for health care service planning and delivery closer to citizens;
- improving the responsiveness and accountability of health care and helping to eliminate cost and blame shifting; and
- making access to health care, health outcomes and health resource allocation much more equitable.

This model proposes that all current health care funding from local, state and federal governments be pooled within a national agency and equitably distributed to RHOs on the basis of evidence about health care needs. Publicly available information on local health needs and health spending (regularly collected in accordance with national standards) would inform decisions by RHOs on the appropriate allocation of services and resources in that region. This approach would benefit consumers, health professionals and governments because it would:

- redress the current inequities in health care access, quality and effectiveness;
- improve clinical co-ordination so that patients can quickly access the most appropriate service provider for their needs;
- improve the collection of data about the specific health services required in different regions;
- integrate planning so that health services develop in coordinated and complementary ways that reflect local needs;
- improve the accountability of health care providers to local communities (with regard to quality, efficiency, access, and health outcomes);
- improve the efficiency of health resource allocation;
- improve the effectiveness of health care by ensuring health care funding is used to address priority health needs;
- increase consumer and citizen input into health service planning and delivery; and,
- increase citizen wellbeing and create healthier communities, with greater potential to improve national productivity and contribute to social and economic development.

Introduction

The health status of many Australians is among the best in the world; however there is ample evidence of gross inequity and inefficiency in our health system, as well as very limited citizen and consumer input into how our health system works.²

The divided responsibility for health care under Australia's federated system of government is one major factor contributing to the unequal and inefficient distribution of health resources to local communities, but it is by no means the only factor.

Much of Australia's health funding is currently distributed via subsidised private spending and enterprise. The unequal allocation of Medicare and PBS funds, Medicare Safety Net funds, and the take-up of public subsidies for private health insurance all demonstrate that this mode of distribution skews resource allocation towards higher socio-economic groups. This is inequitable. A redistribution of funds to regions based on need is required instead.

Health planning has historically focused on physical and human assets (beds, doctors, nurses, etc) while leaving inherited patterns of resource allocation in place. The proposal outlined in this paper would improve health care planning both nationally and at the regional level by using more population based information and information about service providers. A local community-oriented focus would encourage coordination and improve the accountability of health care funding and service provision.

The implications of technological progress, ageing and lifestyle diseases (such as diabetes and obesity) for health care costs are of major concern to policy makers around the world. The current emphasis on hospital care, rather than primary and preventive care, is increasingly recognised as inefficient.³ There is broad agreement that effective primary care reduces health care costs and that improved access to primary health care services in the community would reduce unnecessary admissions to hospitals.⁴ However, our current system of primary care does not deal well with chronic diseases, nor does it work effectively with the acute sector.⁵ To achieve more efficient and equitable outcomes it is not enough simply to shift resources from hospitals to health centres; we must address the social determinants of health, and improve:

- the quality and effectiveness of care,
- access to services for those currently disadvantaged,
- clinical co-ordination, so people can access the most appropriate service provider for their needs,
- integrated planning so that health service sectors can operate in coordinated and complementary ways that reflect local needs,
- access to comprehensive primary health care,
- the accountability of health care providers to local communities, and
- the efficiency of health resource allocation and use.

Current Issues for the Australian health system

Inequity of access to health services and inequitable health outcomes

Substantial inequities in health status exist across different population groups in Australia. This is most alarmingly illustrated by the 17-year life expectancy gap between Indigenous and non-Indigenous Australians.⁶ Such disparities, however, are also quite apparent on both geographical and socio-economic measures, with clear evidence of increased mortality in rural and remote regions and areas of socio-economic disadvantage.⁷ These inequalities

in health status reflect inequitable variations in the effects of the social determinants of health, such as poverty, homelessness, violence, and illiteracy.⁸

Although these inequities and their effects are well documented, **often the people who need health care the most receive the least.**⁹ The rich, urban, and healthy access more health care resources and services than the poor, rural, and sick. The inverse care law applies.

For example, **the combined Medicare and Pharmaceutical Benefits Scheme funding spent on individuals in large capital cities is 23 per cent more than for those in rural or remote areas**, and the gradient of the funding given to inner metropolitan, outer metropolitan, and rural and remote areas, is the reverse of the mortality gradient.¹⁰ Patients are clearly not accessing services as much in the areas of greatest health need. Medicare and PBS funding constitutes over thirty percent of total health expenditure and over sixty percent of non-hospital expenditure but is distributed through providers, not according to need.¹¹ Medicare safety net funds are similarly distributed predominantly to areas of least health need indicating that those with greatest need are failing to access services appropriately.¹² Even when care is accessed, the evidence suggests that the quality of care is less for those whose need is greatest, probably due partly to workforce shortages in areas of disadvantage.¹³ In addition to the geographical barriers, all patients face financial barriers that inevitably have greater impact on those with less financial resources, despite the fact that this group has been identified as of lower health status.¹⁴

The inequitable distribution of resources is linked to the location of service providers and is influenced by inherited patterns of resource allocation (i.e. funding is based on usage not need).

In a system in which services are provided through subsidised private enterprise, with a fee for service model that allows copayment levels and service locations to be decided by service providers, it is not at all surprising that providers tend to work in areas where their patients can afford copayments. Although fee-for-service remuneration is only one reason that there is a gradient of provider numbers from cities, to outer metropolitan, to rural and remote areas, it is a reason that has been completely ignored by policy makers to date. Despite multiple programs to encourage providers to move to areas of workforce shortage, it has proved very difficult to counter the appeal to providers of working in affluent suburbs – including the rewards of fee for service and optional copayments available in cities.

While choice is important for health professionals in decisions about where they live and work, this situation is creating barriers to health care access for many people, as the greatest proportion of health professionals choose affluent, well-serviced metropolitan areas.¹⁵

It also means that many people in other areas are missing out both on services *and* their fair share of health funding, because if services are not provided, funds cannot be used. The disconnect between the location of health resources and the areas of greatest need means that people with significant health needs are not receiving health care services. Resources are allocated according to existing utilisation patterns rather than evidence of health needs (for example data that demonstrates the burden of disease or disability for individuals in each and every community). Consequently, many people with poor health and poor access to services are facing the prospect of their health getting worse.

As all Medicare, PBS, and Medicare Safety Net funds are distributed on the basis of services provided, not services needed, there is inevitably inequitable

distribution of these resources (which constitute almost two thirds of total non-hospital government health expenditure).

Other problems with the fee for service model include the perverse incentive of encouraging episodic care through minimal consultation (thereby discouraging comprehensive, longitudinal care), over-servicing, and the way it limits successful team based approaches to care.¹⁶ It obliges practitioners to act as a small business, when many wish to practice unencumbered by the need for entrepreneurial flair.¹⁷

Inefficiencies in funding affect service delivery

Our health system is plagued by inefficiency, particularly in regard to the division of responsibilities between state and federal governments. This leads to cost shifting, the blame game and the subsequent duplication and lack of accountability and integration of services including data collection on expenditure, resources and health status.¹⁸ Estimates of the cost of duplication and fragmentation range from \$2 to \$8 billion a year.¹⁹

The siloed nature of health professionals' practice, reinforced by fee for service funding,²⁰ results in the provision of services by competitive practitioners who communicate poorly. Combined with the divided funding and subsequent lack of integration of service agencies, this leads to inefficient and ineffective care and weakens the system's capacity for preventative care.²¹

At present, the funding and administration of health care occurs through hundreds of separate, specific programs, many of which do not integrate with others, and it is delivered by health professionals who frequently work in isolation from other members of the health care team.²²

Fragmentation of services, funded and administered by multiple agencies, means a complex and confusing system that is difficult for patients to navigate and leads to poorly coordinated care.²³

The final report of the National Health and Hospitals Reform Commission recognises many of the concerns outlined above.²⁴ Its reform suggestions, however, are inadequate to solve these problems and some will further entrench existing inequities and inefficiencies. For example, while the recommendation to unify responsibility for the funding of primary care is welcome, the continuation of predominantly fee for service remuneration will maintain the siloed nature of care. The recommended extension of the fee for service model to other practitioners, including dentists, will make it even more difficult to integrate services. By itself, the co-location of practitioners in a clinic does not necessarily lead to service integration. In addition, this approach to primary care does not address the need for integration with other services, including hospital care, aged care, and the proposed expansion of subacute care.

The NHHRC report does address the issue of a needs-based increase in funding for rural and remote areas. It fails to explain however why needs-based funding should not apply to all areas, and even in rural and remote locations it does not delegate the control of funds to regions. Whilst the gradual move to 'bundled funding' would be positive, the administration of funds would essentially remain with the Federal Government.

The Commission recommends the establishment of regional Primary Health Care Organisations for the purpose of 'service coordination and population health planning priorities' but gives these organisations a very limited role, and there is no recommendation that their governance include citizens or consumers.

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Importantly, the NHHRC report does recommend data collection on health status, health service use, and health outcomes, along with ‘accessible information on the health of local communities’. The data collected must also include information on health *expenditure* and all such data must be readily accessible so that local communities can use it to drive change.

The Commission’s proposed Medicare Select model appears to have very limited or perhaps no capacity to redistribute funds to areas of increased need and workforce shortage. Funds would continue to follow the provider.

Both equity and efficiency were amongst the key principles that were supposed to guide the National Health and Hospitals Reform Commission. However, despite acknowledging the merits of a model of regional health organisations (outlined as Reform Option B in its interim report), the Commission has in its final report rejected the concept of regional fund holding and local governance.

More promisingly, the Department of Health’s draft National Primary Health Care Strategy²⁵ (recently released for consultation) recommends regional integration as the first building block of its strategy.

Many of these changes could be implemented through a regional governance structure with:

- *strong local leadership and community engagement and support;*
- *clear performance expectations both in terms of identifying population needs and being accountable for progress in meeting those needs; and*
- *funding to drive integration, provide education and training, support change management and ensure gaps in local service delivery arrangements are filled.*

Notably, regional primary health care organisations could manage supplementary funding, targeting those elements of the service system where proactive engagement has the capacity to address traditional areas of market failure, and drive improved outcomes and system efficiencies. Such areas include chronic disease management, a focus on prevention, supporting patient transitions and integrating service responses across the system (including linking to the acute and specialist care sectors).

Responsible regional primary health care organisations could also have a role in reflecting on system effectiveness and relative cost-effectiveness, informing decisions on allocative efficiency across the broader health system, and adapting service solutions to respond to emerging challenges such as changes to clinical practice and new technologies.’

This paper addresses each of these ideas directly and offers ways to overcome each of the challenges associated with a move to regional integration, while retaining the best elements of the current system. The staged implementation proposed below is intended to allow for the adoption of a dramatically improved system of funding and governance – without dramatic interruptions.

What could be achieved by change?

The authors reject the notion that there is no alternative to the status quo. The links between health status and inequality are now well known. The principles of equity, universality, efficiency, transparency and accountability for all parties would be firmly incorporated in the implementation of the reforms proposed by this paper.

The system proposed here seeks to mobilise public funds for health care for broad public benefit. There are potent ethical arguments for a strong publicly funded health care system in Australia, but there are powerful economic arguments as well. This is particularly true for health care that is delivered based on need. Publicly funded health care should provide access to services that lead to equitable health care outcomes. This can be achieved through universal public financing of health care, which provides the economies of scale necessary for technical efficiency, efficient distribution where markets fail, and protection from supply-side moral hazard.²⁶

We propose a single pool of funding distributed regionally based on health need. A single pool of funding will address the fragmentation of services and care, support evidence-based resource allocation, and build more accountable services through improved evaluation.²⁷ While there is currently a considerable amount of evidence on health status at both a national and local level, there are many gaps in existing health care data,²⁸ and little is available in a way that can be accessed by the public in order to drive change. In addition, health expenditure data at the local level is very limited.

This approach offers the opportunity to create a system in which the distribution of health resources reflects the health needs of the local population,²⁹ while the establishment of national standards would underpin equitable quality of care across all communities.

The distribution of funds to regions, combined with the establishment of regional health organisations responsible for service planning and delivery at the regional level, has the capacity to increase integration and co-ordination of care, as extensive evidence from other countries and Australia has shown.³⁰ Such organisations have also been shown to increase the responsiveness of services.³¹ Regionalised needs-based funding would remove some of the current geographical barriers to access, and would also facilitate the removal of some of the financial barriers to access. A similar approach in New Zealand has demonstrated improvements in access to health care and reductions in out-of-pocket costs for consumers.³²

Improvement in health outcomes is central to this proposal. Experience in Canada, the Netherlands, France, Sweden, the UK, and New Zealand demonstrate that regional control of care can improve health care outcomes and integration of care as well as improving service planning and care coordination.³³ Various forms of funds pooling (to break down program silos) linked with local governance and health care commissioning (to empower local stakeholders) have been explored in Australia including in Indigenous communities³⁴ and have been recommended in a number of the discussion papers presented to the National Health and Hospitals Reform Commission.³⁵

This proposal builds on the extensive work both in Australia and overseas to address the widespread problems of our health system at a regional and sub-regional level, using data and regional funding to empower communities to drive change. Over time, this arrangement would lead to a more equitable, coordinated, accountable and effective health care system, responsive to all the factors that influence Australians' health.

The Proposal: The Regional Health Organisation System

This approach would shift the focus of the health system to a regional level, where locally determined health data and the input of local communities will drive change. The distribution of funds to locally governed entities through an equitable and evidence-based formula would address both inequity and inefficiency. This would reduce or eliminate the

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cost shifting and duplication that occurs in the current shared system between federal and state/territory governments, and address the need for local coordination of services to ensure the reflection of local priorities in health care delivery. A staged implementation would allow for capacity building and the retention of many of the excellent elements of the current health system.

Two new entities would be required.

1. National Health Authority (NHA).

The establishment of a single fund for health care in Australia has been advocated for a considerable period on the basis that it would promote the integration of services, improve service coordination, improve allocative efficiency and reduce cost-shifting and blame-shifting.³⁶

Under this proposal, Federal, State, and Territory governments, through the Council of Australian Governments (COAG), would establish the NHA. The total health budget would be determined by governments but the distribution of pooled funds would be based on the needs-based assessment made by the NHA, once governments agree on the methods of the health needs assessment.

All government health funds (including funds currently allocated to the Medical Benefits Scheme (MBS), the Pharmaceutical Benefits Scheme (PBS), Australian Health Care Agreements (AHCAs), Public Health Outcome Funding Agreements (PHOFAs), Department of Veterans Affairs (DVA) funds, aged care, Health and Community Care (HACC), and the private health insurance rebate) would ultimately be pooled for distribution by the NHA, except for public hospital funding. To ensure a smooth transition to RHOs, there would be no immediate changes to the current funding distribution mechanisms and the process of change would be managed in several stages (see below). Public hospital funds would initially be excluded because they may reflect the existing failure of primary health care best exemplified by the fact that per capita public hospital expenditure on Indigenous Australians is twice that of non Indigenous Australians but the ratio for Medicare/PBS funding is the reverse. When primary health care fails, patients require public hospital care which is much more expensive than primary health care. This results in total per capita funding being greater for those for whom primary health care has failed.³⁷

The NHA would be responsible for determining and continuously updating data on health needs and total government health expenditure across regions. This data would be publicly available in an accessible form to drive change within each region. With that information, the NHA would determine the funding allocation for each region, which would be distributed according to health needs. This function would be completely independent of government once a formula for needs-based health funding is determined by the NHA in consultation with government.

National benchmarks for general health status, the health status of specific groups, access to health care, and standards of social determinants such as housing and education, would be established. The setting of national benchmarks would be either a Federal or combined Federal/State responsibility in combination with the NHA. It would be crucial that such benchmarks specifically address the needs of marginalised groups to prevent regions 'cherry-picking' the more easily achievable benchmarks, which may lead to continuation of disadvantage in marginalised groups.

2. Regional Health Organisation (RHO).

Size

The RHO organisations would be responsible for the distribution of health care funding for the population in each region of approximately 200,000-400,000 people. Across Australia, this would mean the establishment of 50 to 100 RHOs, depending on population distribution. This size is considered optimum due to its consistency with the size of local government regions. It is also large enough to ensure the region can be principally self-sufficient, attract staff, wield necessary influence with decision makers, and minimise problems of excess risk exposure.³⁸

Governance

Each RHO would be established according to nationally mandated governance structures, with clearly defined roles and expectations. RHOs would be established as incorporated bodies, and the criteria for appointments to their boards would include health expertise, business acumen and local community representation. Representatives of local government, local GP divisions, current area health services or equivalents and community health centres should all be considered when executive boards are appointed. Importantly, there should be sufficient citizen/consumer input to prevent domination of the board by specific interests, and where appropriate, there should be representatives from Aboriginal Controlled Community Health Services (ACCHS). RHOs would require strong community links to be truly effective, with enough leverage to encourage the vertical silos and private providers to develop their programs in complementary and collaborative ways and also to mobilise community action for health gain. The establishment of strong community governance structures is considered an important factor in improving the quality, cost-effectiveness and efficiency of health care services as well as access and equity.³⁹

Information on Health Needs

The RHOs would work with government and the NHA to identify regional and intra-regional health needs, service utilisation patterns, and health spending. This information would require constant reassessment to maintain its relevance and would form the basis for the development of proposals for change. This local knowledge would facilitate the development of locally responsive services based on the particular health care needs of the local community.⁴⁰

Funding

The ultimate role of the RHO, when fully developed, would be to control all health funds for the region and purchase or commission services from local health providers. This would enable the creation of an integrated system where all health care services are coordinated but not necessarily co-located. **The RHO would not be a service provider.**

Each RHO would be provided with incentive and developmental funds from the NHA. Commonwealth, state and local governments would work with the NHA to generate regional health accounts based on population health needs. These accounts would show revenue sources and expenditure patterns for the population in each region, supplemented by comprehensive data on utilisation and servicing rates and health status measures.

With comprehensive information on the health status and needs of the local community, the RHO could then submit proposals for funding to the NHA to address specific inequities and inefficiencies. There would be several incentives for RHOs to develop proposals. These would include financial incentives, the need for accountability, and the opportunity to develop locally relevant programs. Firstly, proposals would attract funding. Secondly,

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public disclosure of the health needs and health expenditure of the region would generate pressure on the RHO to address such needs. Thirdly, accurate knowledge of health needs would enable RHOs to develop appropriate proposals.

Similarly, there would be incentives to implement proposals. The ongoing assessment of health needs and health spending would help to reveal the success of such proposals and the results of assessments would be publicly available to maximise accountability.

Direct funding would be required to set up and run the RHOs. The amount of funding available for health services would depend on funding already present in the region, compared to its measured health need. RHOs that were already well funded would receive a nominated percentage increase to allow for innovation. Thus, no region would have a decrease in real funding over time. Funding available to all other RHOs would be up to the level of the best funded RHO for equal health need but with a loading for lower health status. Any savings from the implementation of proposals would be returned to the administering central authority, and thus be available for further proposals. Over time, there would be a progressive increase in the proportion of government funding available to RHOs. This would provide poorer RHOs with additional resources to address health needs by commissioning the services required.

Each RHO would be responsible for meeting the health needs of its own population, providing an incentive to ensure that services are effective in terms of health care outcomes. This also means RHOs have the flexibility to ensure funds are allocated to services that are cost-effective. All existing organisations and providers, including State Governments, would be involved. No current health providers would be prevented from continuing to provide services, but over time the way in which those services are provided would need to be negotiated with the RHO and the local community. While there is room in this approach for the retention of fee-for-service mechanisms for the remuneration of some services, it is anticipated that this would diminish over time, and other forms of payments be substituted.

RHOs could negotiate with individual and group practices whatever funding arrangements they felt would serve the needs of patients most efficiently and equitably. Thus, for example, Medicare rebates would continue unless a RHO decided to move to partial or total salaried service. Within regions, some services may eventually receive less funds whilst funding for other services would increase as the RHO directs its funds to the most appropriate, cost effective service that allows it to work towards the national benchmarks in ways that stakeholders agree are appropriate.

Individuals will move from region to region, mainly for non medical reasons, but sometimes to access services available in one region but not in their own. Funding should follow the individual and come from their region of residence. This would be expected for more expensive technological care only available in tertiary capital city hospitals (outlined in Stage Five below). Whilst this cross regional drift may be a problem where one region consciously refuses to fund a certain treatment and another agrees to such funding, it is likely, with appropriate national benchmarks (and much broader public scrutiny than has ever been envisaged previously) that this would only be a minor issue.

State by State opt in

This approach could be implemented on a state by state basis, wherever the local, state and federal governments can work together.⁴¹ Thus, those state governments that wish to be a part of such a scheme could enter into a political agreement with the Commonwealth to directly fund RHOs. The alternative, and less feasible, governance model would require constitutional change through a referendum to enable the Commonwealth Government to override state government responsibilities in health. State governments would continue to

be providers of services, but as RHOs develop, the role of both state and federal governments with respect to planning and co-ordination of care would be reduced. However, state governments would still be a significant service provider, especially of hospital services. In this model, all current providers would continue to deliver services provided they meet the accountability and service requirements of the RHO.

Canadian model

Regionalisation of health care governance in Canada provides useful lessons for Australia. Regional governance has been introduced incrementally in nine provinces and the outcomes are positive, with less fragmentation, less duplication, more streamlined care, and improved care coordination. With sound accountability mechanisms in place, the effectiveness of resource allocation is improved with greater alignment between health needs and resources.⁴² Central to its success however, is a clear mandate, commitment to the process by all partners, strong leadership, and a shared vision to mobilise providers and the community.

Implementation

The implementation of the RHO system in Australia would involve several stages, which are outlined below.

Stage One

The first stage requires the establishment of the National Health Authority (NHA) and the Regional Health Organisations (RHOs) to cover specifically designated geographical areas and populations throughout Australia. Establishment of the RHOs could be done nationally or at an individual state/territory level: thus it requires only individual state co-operation, some states could take part whilst other states avoided participation.

The RHO would commence functioning principally as an advocacy/data collection organization. This recognises the fact that it will take time to collect and analyse data in the form required and time will also be needed to develop capacity and expertise in the RHOs.

Thus, initially, the RHO would be responsible for the identification of local health utilisation patterns and local health needs. This task would require local assessment tools combined with federal, state and local government information on total health spending and assessment of health needs. The federal, state and local governments will need to mobilise information resources and planning tools for RHOs to enable them to systematically appraise health needs, health care utilisation and expenditure and scope for achieving health outcomes.

This information would require constant reassessment to maintain its relevance and would form the basis for the development of proposals for change. It would also be available to the public in a form that would clearly facilitate accountability. The NHA would be responsible for auditing this process.

Stage Two

Once established, any new funding for health services determined by government would be distributed to RHOs based on identified need. The RHO would be responsible for the allocation of these funds within the region through commissioning.

Stage Three

Each RHO would identify specific areas of health need in their region, and in discussion with health care providers and taking into consideration the national standards and

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benchmarks, would develop proposals for funding to address such needs. These would be funded by the NHA and assessed independently over time.

For example, if inappropriately high antibiotic prescribing was identified, a proposal to educate prescribers would be funded, and if it had the desired result, the RHO would then have more funds available for other activities. If diabetes was identified as a bigger burden of disease for the area than other areas, the RHO would propose a plan to suit their local needs to address the issue.

Access to appropriate housing, the welfare system or to employment may be identified by the RHO as important 'social determinants of health' for its population. The RHO might decide to invest in more case workers to advocate on behalf of patients. It might also address the housing issue by submitting proposals for funding improvements as well as advocating for change, perhaps in combination with other RHOs.

Funding for such proposals could include the use of current funding used in a different way, determined by the RHO in consultation with providers. Thus, the proposal may wish to use some specific purpose funding which already exists, combining it with increased funding as justified by the needs based formula, but spending it in a different manner to that currently mandated by government.

Identifying a lack of aged care beds in the region could result in a proposal to fund such beds. In addition to that funding, there could be a 'bonus' for the RHO. The RHO could use its resources to provide the services needed, eliminating the need for elderly people to move. If there is no spare funding, but it is also identified that there is unprecedented spending on dental care, the proposal might be to look firstly at how to improve the spending on aged care, but also on more appropriate spending on dental health for the privately insured, freeing up more money for aged care. RHOs could combine with each other to identify problems relating, for example, to program-based rather than patient-centred funding which results in difficulties delivering the best care locally. Proposals to simplify funding could then be submitted in the same way as other proposals.

Stage Four

Medical Benefits rebates and Pharmaceutical Benefits combined are the largest component of primary health care costs. These would form part of the pool that the NHA would measure and ultimately control. Once an RHO had the expertise and capacity to administer this component of funding, it could request all or part of these payments be disbursed for the region to use in a different way. Thus, it could choose to abandon fee-for-service payments except for episodic care, combining this with patient registration. It may choose to maintain fee for service if it feels, and the data indicates, that it is the best way to achieve national benchmarks. If it is underserved by specialists, it may choose to apply for additional funding for salaried specialist services.

Regions that currently struggle with a shortage of health professionals (and consequent poorer health standards) would be eligible for extra funding to address underfunding and greater health need. A RHO would then use this funding in accordance with its population's specific needs and the availability of suitable health professionals. For example, it could offer a bonus to a GP to work in a fee for service model, offer a substantial salary for a GP to work in a team within a multidisciplinary clinic or attract nurse practitioners and/or some allied health professionals with bonuses and attractive conditions.

If poor health associated with mental illness was identified within a region and prioritised, the RHO could submit proposals to address the issue. This would be done in the context of the national benchmarks, which would need to specifically address the various needs of this

particular marginalised group. A lack of access to health professionals, from psychiatrists through to mental health trained social workers, would clearly be a priority. The RHO could identify which mix of health professionals would suit its needs best within the capacity of the funds available and the capacity to attract such professionals. It would work with the established organisations and provider groups to develop the proposal.

In carrying out its responsibility to smooth patients' pathways through primary, community and hospital care, the RHO might identify poor communication between hospitals and GPs as a problem, and develop proposals to improve communication.

Stage Five

Hospital costs are the single largest component of health care spending. Regions as described would not necessarily have the hospital expertise within their area. Funding however, relates to patients in the area rather than to services. In this stage, it would be possible for the RHO to commence purchasing services from hospitals both in its area and in adjoining areas. Firstly however, public hospital funding would need to be incorporated into the funding pool. In regions with very high public hospital funding, detailed consideration of health status would enable an assessment of the contribution of inadequate primary health care to a disproportionate amount of public hospital funding in a particular regions. Allowance for that could then be made, especially given that this would be happening after some years of experience analysing patterns of health need and health expenditure.

State hospitals would then shift from being funders of hospital and health services to service providers. They may however remain the owners of hospital infrastructure, with provisions available through the funding authority for distribution of funds for upgrades of infrastructure. State governments would have an important role in providing expertise in establishing the RHOs and supporting the planning work. Over time, this role could change, with ownership of major hospital infrastructure shifting to the Commonwealth.

This model involves substantial change from the current systems of governance and financing in Australian health care: the extent of change proposed here is in proportion to the extent of inefficiencies that must be overcome. The staged introduction of this system outlined above would see the retention of all current service providers; however the financing of their services would shift over time from the current local, state or federal government, to services purchased or commissioned by the Regional Health Organisation.

Respective Roles and Responsibilities

The following table explains the specific responsibilities of RHOs, the NHA and Government.

RHO	NHA	Government
Work with governments and the NHA to continually assess health needs, health outcomes, and health service utilisation in the local population/region and make such assessments publicly available.	Develop a needs based funding system for regions based on a continuous audit of health expenditure and health need.	Provide data and support for assessment of health needs, outcomes, and health service utilisation (Federal, State, Local) in collaboration with the NHA.
Develop proposals to improve equity, health outcomes, and efficient health service utilization based on the information collected.	Assess and fund proposals from RHOs.	Set national benchmarks and standards in collaboration with the NHA by which RHO can determine quality of local service (Federal with State).
Implement such proposals by commissioning appropriate services.	Assess the success of the proposals measured against national benchmarks.	Determine the total health budget (Federal/COAG).
Oversee the delivery and coordination of health services to the local community by commissioning the services of health care providers.	Evaluate and audit performance of RHOs.	
Provide a coordinating function for the delivery of all health services in the region e.g. for the transition of individuals through the health system.	Maintain records of revenue sources and expenditure patterns for each region, including comprehensive data on utilisation and servicing rates and health status measures.	
Advocate for resources to ensure the health needs of the population in the region are being met.		

Potential barriers

While the stages outlined above have been carefully designed to enable a smooth transition, as with any major change, there are a range of potential barriers to the successful implementation of the RHO model.

- **Political:** Many politically influential stakeholders will be resistant to changes to their functions and to decreased control of information about health service function. Federal, State/Territory, and Local Governments may be reluctant to transfer financial resources and responsibility to new untried local organisations. It is likely that large hospitals and autonomous private operators would be suspicious of any new structures exercising the 'commissioning function' at the local community level. Whilst these concerns have merit, the gradual implementation of this proposal would ensure there are no rapid changes. Initially, the budgetary responsibilities of the RHOs would be small. Governments would be considering a notional budget for each region, which would be spent by the RHO. Until the RHO develops proposals to use resources differently, nothing would change. Thus, no government would suddenly (or even in one or two years) be giving up a huge proportion of its budget or authority or responsibility. The governance of the RHO is crucial to this. It must be inclusive of all stakeholders including government, public and private providers and insurers, and citizens.
- **Administrative:** The information sets and skill sets required to exercise local influence over service coordination and to exact tighter provider accountability are substantial. The establishment of RHOs will require the utilisation of the skills within existing organisations as RHOs develop capacity and expertise. Health providers will understandably resist any increase in administrative activities that are not properly resourced. The skills required by the RHO and new skills required by health providers will not be immediately accessible and will take time to develop. Data recording, collection, analysis, and publication are central to accountability in this new structure. This will also require time and adequate resources to develop. Data collection will need to be sufficiently responsive to ensure that further marginalisation of already disadvantaged groups in a region is avoided. Whilst it may be argued that this proposal would simply add more bureaucracy to a system already overloaded with bureaucrats, many of the new functions required would use the same bureaucrats that already exist, such as those collecting vast amounts of data in silos in different health departments throughout the country. This part of the process could even be cost neutral as there would be less duplication of data collection and analysis.

To minimise administrative duplication it would be necessary to transfer the purchasing functions of Medicare Australia, the Commonwealth health department and the state and territory health departments in some degree to local entities.

- **Institutional:** While there is a rich mix of local government, primary health care and local community organisations operating at the local community level, there is not a strong culture of total health system oversight, nor are existing networks and constituencies oriented around supporting these functions. Part of the work of RHOs will be building relationships and cooperating with local organisations to capitalise on these collective resources.
- **Governance:** The model for the RHOs must clearly delineate roles and responsibilities and be adequately resourced to enhance effective functioning and capacity building. Governance structures must include all stakeholder groups, such as local citizens, local government, local GP divisions, current area health services or

equivalent, and community health centres. It will be vital that governance frameworks are established to avoid 'capture' of RHOs by special interest groups.

- **Cost:** There will be increased financial costs in the development of both the NHA and the RHOs. Once new funding begins to be distributed, there will be further costs. However, the development of much more targeted and effective care at the primary and local level has the potential to reduce expenditure and improve productive capacity in the long term. Concerns were raised by the NHHRC regarding economies of scale in geographically dispersed regions. This issue exists irrespective of regional funding - it could be argued that a locally responsive organisation is more likely to look for efficiencies without reducing services than a more centralised organisation.
- **Geography:** One of the major challenges in achieving equitable access as opposed to equitable *entitlement* is the lack of health care providers as one moves from richer inner urban areas to rural areas. Multiple programs and initiatives have attempted to address this problem, with limited success. It may continue to be difficult to attract providers to regions that are currently underserved. In the RHO model, the funds to attract such providers will be in the region, and the region will have the capacity to be innovative in the way it uses those funds, e.g. for telemedicine, transport, nurse practitioners, or physicians' assistants, without their local solution having to fit in with a Canberra-based program and budget. Over time, providers will move to where funds are available, rather than the reverse, which characterises the current situation.
- **Complexity:** Determining a needs-based funding model is complex and is an evolving science. There is much to learn and the model would need constant attention and revision to address concerns and problems as they are identified. Cross-border flows of patients also add to the complexity of regionalisation. However while the NHHRC suggests that these complexities are grounds for rejecting the concept, many would disagree.⁴³ The alternatives proposed by the NHHRC do not adequately address the many problems that have been identified in our current system.

The key to the implementation of this proposal is that it is incremental, with small initial costs, and with time to build capacity in the RHOs, build relationships between RHOs and providers, develop appropriate governance skills, and give the NHA the time to build its capacity.

Incremental change is necessary. Creating a local focus of power, which can drive a myriad of local modifications, must be seen as an incremental process. The most important dimensions of this process are the provision of information resources, the focus on institutional development, and the mobilisation of advocacy and financial power to drive the coordination and accountability needed.

Proposed timeline

This system of devolved health care governance could begin as soon as agreement could be reached at COAG or between an individual state or territory and the federal government to establish RHOs. Once agreement was reached, an independent agency could be created to hold funds, RHOs could be established and the process of establishing local data sets commenced. As soon as these were available, and the RHO governance structure established, Stage One of the implementation would be underway. It is estimated that this could occur within twelve months of governmental agreement.

Benefits of a health system driven through RHOs

There is an emerging view among public policy experts in Australia that a greater emphasis on national policy, supported by stronger regional governance, could provide more responsive, effective, legitimate, and efficient forms of governance.⁴⁴

This approach to health care governance will deliver the following benefits:

- greater community participation in the planning and delivery of health services;
- improved integration and coordination of services;
- improved health outcomes; and
- improvements in equity and efficiency.

Community

The benefits to the community of a system coordinated through RHOs would be considerable. Such benefits have been seen in other countries where similar regionalisation has occurred, although in each country the different pre-existing services necessitate different approaches to the process. Expected benefits in an Australian context include the following:

- Pathways of care would be clearer and more coherent;
- Individual care would be better coordinated;
- Greater incentives for prevention and health promotion activities would be provided;
- Health care service planning would be improved;
- Access and equity would be improved;
- Greater opportunity would arise for local community governance to influence the distribution of health funding;
- Responsiveness, appropriateness, and effectiveness of services would be improved;
- Duplication of services and cost-shifting would be minimised;
- Service effectiveness and quality of care would be improved by delivering locally responsive services according to nationally agreed standards;
- Transparency and accountability in health care financing and expenditure would be improved; and,
- Individual and population health outcomes would be improved as locally monitored health outcomes will help drive priorities for service provision.

Government

The benefits to government (which ultimately benefit the community) would include:

- Technical and allocative efficiency in the distribution of resources would be improved;
- Health system effectiveness would increase and wasted resources would be reduced as funding would go to services that are needed;
- Costs of tertiary services may be reduced as acute care admissions gradually fall;
- Local communities would be able to accept some accountability (and some responsibility) for health outcomes; and,
- Improved health care outcomes would enhance national productivity.

Health Professionals

The ability to effect population health changes, by working through an RHO-driven system, would offer improved professional satisfaction, enhanced opportunities for professional support, and help reduce burnout and turnover among dissatisfied and overburdened health professionals. The benefits for health professionals would also include:

- The opportunity to work in a coordinated system providing services that are determined according to health needs;
- Improved clinical co-ordination allowing the skills of providers to be utilised more effectively;
- Better access to data and better understanding of the needs of the community, allowing them to develop appropriate skills sets to meet community needs;
- Professional feedback to health care providers, via the collection of data regarding regional health care outcomes allowing for continuous improvement; and,
- Consumer and citizen input allowing greater opportunities for true partnerships in care.

Conclusion

The RHO model proposed here involves moving health care governance and funding to regional agencies, and ensuring that they have the information and funding to be more responsive to the needs of communities. This model could address the fragmentation and duplication plaguing the current system and would lead to fairer and more effective health care in Australia.

There are important precedents for this proposal in other jurisdictions and compelling arguments for significant change to the funding and governance of Australian health care. The devolution of health care funding to regions based on need has been the basis of much advocacy for health care reform in Australia, on the basis that it will improve equity and efficiency. This proposal offers a staged implementation of such a system that, if carefully managed, would provide the framework needed to achieve these aims. The establishment of RHOs in Australia would address the most fundamental challenges facing our health care system. It would create a responsive, accountable health care system, in which consumer needs are the basis of the system, providers are rewarded for quality care, and health care dollars are used where they are most needed and can make the most difference.

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