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Can we get there from here? Implementing Health Reform in Australia

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Project team

Jane Hall[a]
Patricia Kenny[a]
Prue Power[2]

[a] Centre for Health Economics Research and Evaluation (CHERE)
University of Technology Sydney, PO Box 123, Broadway NSW 2007 Australia
[2] Australian Healthcare and Hospitals Association (AHHA)
PO Box 78, Deakin West ACT 2600 Australia

Contact details

Ms Patricia Kenny
Centre for Health Economics Research and Evaluation (CHERE)
University of Technology, Sydney
Level 4, Mary Ann House
645 Harris Street
ULTIMO NSW 2007

Tel: + 61 2 9514 4750
Fax: + 61 2 9514 4730
Email: patsy.kenny@chere.uts.edu.au

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Abstract

The Australian Health Reform Agreement has provided the basis for major change in the delivery of health care services. While the components of reform have undergone extensive negotiation between Commonwealth and State governments, and have been subject to academic and other commentary, little is known about the views of those charged with their implementation. This paper reports the opinions of key informants working in public health care during the early implementation period. It seeks to ascertain their views on the health system and the direction of the reforms, the likely effects and barriers to successful implementation.

An anonymous online survey of 138 members of the Australian Healthcare and Hospitals Association (AHHA) was conducted in late 2011. The survey covered opinions about what was happening in the health system and the need for reform, access to information about the reforms, how changes were being effected and the perceived barriers to implementing activity based funding, and public performance reporting, and their perceptions of Medicare Locals and Super Clinics.

Seventy-eight percent of respondents thought that fundamental reform of the system was needed but only 5% thought the current reforms would deliver the required improvements. Only 9% expected the new arrangements to remove the 'blame game' between the Commonwealth and States/Territories. Potential barriers to the implementation of the reforms included agreement among the Commonwealth and States, availability of alternatives to acute hospital care, valid measures of activity and performance and establishing appropriate funding models for Medicare Locals. The survey provides evidence that, among those involved in implementing the changes, there are perceptions of barriers to

be overcome in implementing the reform agenda and there is an expectation that further reform will be needed.

Introduction

In 2010, the Australian Prime Minister (Rudd, at that time) described the current round of national health reforms as "the most significant reform of Australia's health and hospital system since the introduction of Medicare almost three decades ago."(1) The key features of these reforms are improving the incentives for efficiency in hospital care, increasing transparency and accountability in the system, and providing more local autonomy and responsibility in decision-making.(2) These strategies bear much similarity to developments in other developed countries, and so too does the emphasis on clinician engagement and leadership.(3). In Australia, a key component of reform implementation is the establishment of Lead Clinicians' Groups, which are designed to enhance clinical engagement and leadership.(4) However, much less attention has been paid to management and the role of managers in effecting change. Indeed, the main concern of politicians in respect of management seems to be to ensure that there is no further growth in 'bureaucracy'.

Concern has been expressed that professional subcultures can resist the implementation of reform.(5) While there is a clear case for supporting clinician engagement, we believe that professional managers also play a key role in the implementation of reforms. If greater local autonomy is achieved, then the role of this group will change from a focus on budget responsibility to a stronger focus on leadership, value for money and population health outcomes. If indeed, this reform is to be the most significant in decades, rather than just incremental, then it requires a change of organisational culture. "Conceptually, there is no debate about the fact that the vision has to be a shared vision ….".(6)

Therefore gaining some insight into the attitudes and opinions of such key decision makers can be a useful early indicator of whether reform can be successful. This paper reports a survey of health services managers, administrators and executives carried out at the end of

2011, at the beginning of the reform process, with the intention of gauging their attitudes to reform directions, and perceptions of barriers to implementation. A similar approach has been used in exploring other areas of policy implementation. Surveys of key informants have been reported for the Clinical Services Redesign Program in NSW,(7) health technology assessment,(8) hospital use of high cost medications(9) and for workforce policy.(10)

Recent Developments in the Australian Health Care System

In 1984, the establishment of Medicare (and its predecessor Medibank, established in 1975) marked a move to health financing based on tax funded, universal access to hospital and medical services. Medicare has remained popular with voters, and has been resistant to major change in spite of the continuing tension between public and private interests, and dispute about the role of private health insurance.(7) However, Medicare was imposed on the extant Commonwealth-State relationships and shared responsibilities for health. The Commonwealth has responsibility for the regulation of health insurance, pharmaceutical benefits and benefits paid for medical services. Public hospitals are the responsibility of State governments, but the Commonwealth with its greater revenue raising powers has supported the State and Territory funding of public hospitals since the immediate post World War II period. With the establishment of Medicare, the Commonwealth took a much greater role in public hospital funding, compensating State/Territory Treasuries for universal access to free treatment in public hospitals. That Commonwealth contribution has been determined through five yearly agreements negotiated between the Commonwealth and the States and Territories (from here on States should be taken to include Territories). The Commonwealth share has fluctuated, and with increasing pressure on public hospital services and budgets, the split of responsibilities between the two levels of government allowed each to blame the other for shortcomings in the hospital system.(8, 9) Indeed, the

tension between the two levels of government, regularly described as 'the blame game', led many commentators to wish for the responsibility for funding health care to rest with only one level of government.

Ending the blame game was the key message of Kevin Rudd's health policy for the 2007 election. The Rudd government established the National Health and Hospitals Reform Commission to develop a blueprint for the future health system. The Commission's report recommended a shift to increasing Commonwealth funding of public hospitals initially, and subsequently the development of a competitive market for private health insurance with a publicly operated plan as the default option.(10) Following further consultation, the Rudd government did not adopt the competitive insurance model, but proposed a national system of hospital governance with more local autonomy, backed up by financing reforms under which the Commonwealth would provide 60% of (efficient) hospital funding.(11) However health reform requires the agreement of the States and this was not achieved until August 2011, with further modifications to the Rudd proposals. In the final National Health Reform Agreement, the key elements are the establishment of local governing bodies for public hospitals which will receive the Commonwealth contribution to hospital funding directly, based on their activity and case-mix; emphasis on the States' role as managers of the public hospital system; more transparency in funding flows; and greater accountability both for funds and for performance. Alongside this, is the setting up of local bodies to co-ordinate and plan primary care services from a population perspective (now called Medicare Locals), and new strategies to fill gaps in primary and community care. This required the establishment of several new agencies.

By the start of 2011, there had been much discussion but little achievement. Since then, the National Health Reform Agreement has been reached by the Commonwealth and all the

State and Territory Governments; the States have established Local Hospital Networks; the new Medicare Locals have been determined; the new Australian National Preventive Health Agency, the National Health Performance Authority and the Independent Hospital Pricing Authority have been established and are functioning. Activity based funding commenced on 1 July 2012.

Medicare represented a major rearrangement of health care financing but largely left service delivery intact. The new National Reform Agreement lays out an ambitious program which is about how the Commonwealth and States work together to improve service delivery, with much emphasis on local action. It will take some time before measures of change in patient satisfaction, in health outcomes, and in efficiency are available. What we can assess is how those involved in implementing the changes at the clinical and managerial interface, perceive the direction and progress of the reforms. Much of the implementation, as opposed to the design, of reforms relies on changing the behaviour of the managers and the clinical providers in the system. The health system does not operate through a command hierarchy; rather the outcomes in terms of health and efficiency are the results of the individual decisions and behaviour of the many actors within the system. Financial and other incentives are the levers through which policy makers attempt to change those behaviours. But such incentives may prove ineffective, if those actors are not equipped with the tools to make change, or hold attitudes which are inimical to change in the desired direction.

Methods

The sample was recruited through the Australian Healthcare and Hospitals Association (AHHA), by placing a notice about the survey in the electronic newsletter *E-Healthcare Brief,* distributed by the AHHA to a mailing list comprising 5,600 members and other interested individuals from throughout the health services sector. The AHHA membership

includes institutions such as state health departments and local healthcare organisations, as well as individuals working in health policy and in the healthcare sector generally. A filtering question was used to ensure that only respondents currently working in a public hospital, a community health service, a local network administration or a central health agency or health bureaucracy could proceed with the questionnaire. After completion of the survey, respondents were then asked to recommend colleagues we could approach to participate in the survey. This approach is similar to the snowballing technique used by qualitative researchers to recruit key informants from groups who are difficult to identify.(12) We took this approach as the target population comes from a broad range of disciplinary backgrounds and could not be identified through a single employer or professional registry. Further, to facilitate open responses, it was important that the research was seen as independent from Commonwealth and State/Territory health departments. Consequently, we did not attempt recruitment through health departments.

Data were collected through an online survey which covered opinions about what was happening in the health system and the need for reform, access to information about the reforms and how changes were being effected. There were also detailed questions about the key elements of the reforms, the potential for success and barriers to implementation of the strategies and for establishing the new organisations. Some questions specific to reform elements were not asked of all respondents; for example questions about the barriers to implementing hospital funding were not asked of community health respondents and questions about the barriers to establishing Medicare Locals were not asked of public hospital respondents. Local network respondents and central agency/bureaucracy respondents were asked all questions. The survey was designed specifically for the study and drew on some questions from the Commonwealth Fund survey to allow comparisons with previous surveys.(13) Respondents were also asked about their sector of the health

system, their time in the Australian system and their time in the current position. The survey was tested in-house at CHERE and the AHHA where staff completed it and provided feedback; the survey was edited accordingly.

Data were collected between September and November 2011. Information about the survey and a link to the online survey were included in the AHHA newsletter on 31st August. There were 180 respondents of whom, 123 completed the survey. These responses yielded 46 email contacts for additional potential respondents who were contacted 9th November; of these 15 completed the survey. As this group of responding contacts had similar characteristics to the original sample, it was decided to pool the two samples for analysis, providing a total sample of 138. The contact respondents included slightly more females (67% versus 59%) and slightly more with management or allied health as the main discipline area/training (management 33% versus 25% and allied health 27% versus 13%) but were similar in terms of the sector of the health system, years in the system and years in the current position.

As the intent of the survey was to ascertain opinions, data analysis simply used frequency counts to describe question responses. These are presented by four sectors of the health system: public hospital, community health service, local network administration and central health agency/health bureaucracy.

Results

Sample Characteristics

Of the 138 respondents, 33 (24%) worked in a public hospital, 38 (28%) in a community health service, 17 (12%) in local health network administration and 50 (36%) in a central health agency/health bureaucracy. More than half had worked in the Australian health care

system for over 20 years (mean 22.4 years, standard deviation 11.6) and more than half had held the current position for three years or less (mean 5.6 years, standard deviation 6.0). Sixty percent were female and the main discipline/training areas were management (26%), nursing (25%), public policy (19%), allied health (14%) medicine (8%) other (8%), (see Table 1).

Table 1: The characteristics of respondents

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=49)	Total % (n=137)
Female	61	68	47	57	60
Years Aust. Health system					
1-10	12	18	12	31	20
11-20	21	24	24	27	24
21-30	33	32	29	35	33
30-46	33	26	35	8	23
Years current position					
1	21	11	29	27	21
2	15	16	24	24	20
3	12	5	6	16	11
4-5	3	29	12	12	15
6-9	12	13	6	14	12
10 or more	36	26	24	6	21
Main discipline/training					
Medicine	15	3	18	4	8
Nursing	30	32	18	18	25
Allied health	12	16	18	12	14
Management	24	37	29	18	26
Public policy	6	13	12	35	19
Other	12	0	6	12	8

Need for reform and likely outcome

The respondents' views of the health system before the reform process commenced and the expected impact of the reforms overall are illustrated in Figures 1 and 2 respectively. The majority of respondents (78%) thought that fundamental reform of the health system was needed (Figure 1) and this did not vary substantially between respondents from different

parts of the health system (see Table 2). Most also thought that the current reforms would be implemented, although not as scheduled (see Table 2). Few respondents (5%) thought that these reforms would deliver the improvements the health system needs (Figure 2); 26% thought that further changes would be required, while 36% thought that fundamental reform would still be required (Figure 2). Twenty-two percent of respondents thought that the reforms would make little difference or would make things worse; this negative view of the expected impact of the reforms was more common among public hospital respondents (reported by 30%, see Table 2).

Figure 1: Respondents' views of the health care system before the start of the reforms

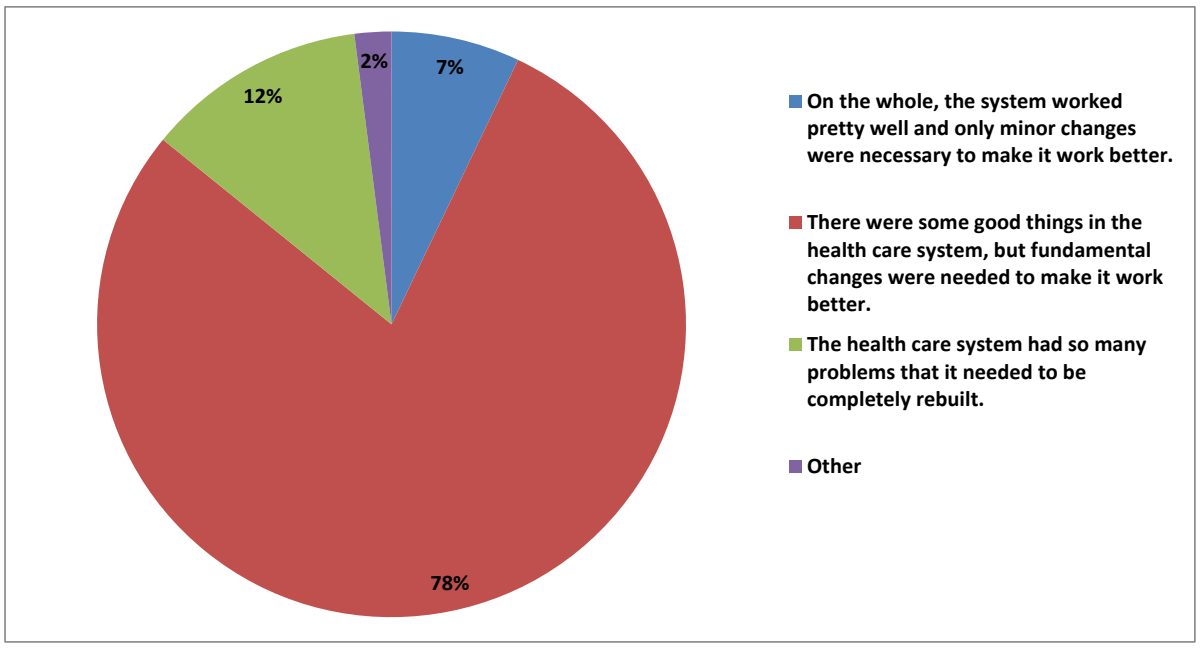

Figure 2: Respondents' views of the likely impact of the health reforms

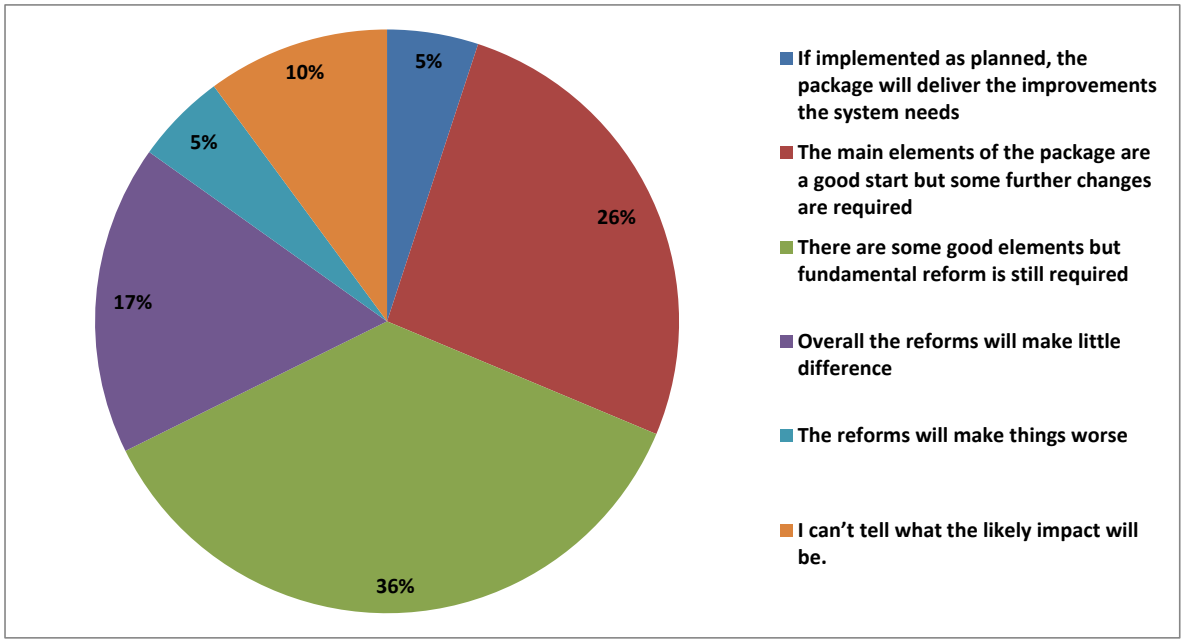

Table 2: Respondents' opinions about the reforms in general

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=138)
Overall view of system before reform	12	3	6	8	7
Only minor change needed	70	82	82	80	78
Fundamental change needed	15	11	12	12	12
Needed to be rebuilt	3	5	0	0	2
Other					
Overall likely impact of reforms					
If implemented will deliver needed improvements	3	5	6	6	5
Further change required	15	26	35	30	26
Fundamental reform still required	33	39	41	34	36
Will make little difference	18	18	12	18	17
Will make things worse	12	3	0	4	5
Can't tell what impact will be	18	8	6	8	10
Likely success of implementation					
Implemented as planned	9	11	12	8	9
Implemented but not as scheduled	76	74	71	82	77
Unlikely to be implemented mostly	15	16	18	10	14

Information and feedback

Just over half of respondents reported receiving information about the reforms from federal or state health departments, while a third relied on searching for information themselves. Only 10% reported not feeling well-informed about the reforms, while 61% felt well informed about all or most reform elements. When asked about specific elements of the reform, less than half thought they were well informed about each of the four key elements. The National Performance Authority and Medicare Locals were the elements where the fewest respondents were informed, particularly those from public hospitals (Table 3). A substantial minority (42%) felt that there was little or no opportunity in their workplace to provide feedback about how the reforms were affecting their part of the health system.

Table 3: Respondents' access to information about the reforms

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=138)
Information source					
Health dept regularly	27	29	6	28	25
Health dept not regularly	36	32	29	20	28
Search for information	30	29	53	34	34
Other*	6	10	12	18	12
Well informed about reforms					
All elements	9	8	24	26	17
Most elements	45	53	24	44	44
A few elements	21	37	47	22	29
Not well informed	24	3	6	8	10
Feel well informed about**					
National Performance Authority	12	18	35	38	26
	36	34	47	50	42
New hospital funding approach	9	45	35	40	33
Medicare locals	27	61	53	54	49
GP Super Clinics					
Opportunities for feedback					
Good opportunities	15	16	35	28	22
To some extent	30	37	29	40	36
Little opportunity	39	37	24	22	30
No opportunity	15	11	12	10	12

*Multiple sources including: Professional organisations, News media, direct involvement with reforms.
**Percent who responded 'Yes' to each item.

Public reporting

There was general support among respondents for independent public reporting on clinical outcomes, patient experiences and safety and quality (supported by 80-90%, Table 4); this level of support applied to reporting for both hospital and community health services. However, there were also a number of barriers identified; media coverage, performance measures for non-acute services and consistent data from different services and from states and territories were most frequently identified as major problems for implementing public reporting (54-63%, see Table 5). A higher proportion of public hospital respondents than other respondents were concerned about media coverage of performance reports; identified as a major problem by 85% of public hospital respondents. The extent to which the public would understand performance reports and the capacity to adjust for the community served were also identified as major problems for implementation by the majority of public hospital respondents, although just under half of all respondents thought these were major problems (49% and 42% respectively). Commonwealth-state relationships and reporting that bypasses states were seen as major problems by 46% and 47% respectively (Table 5). Note that all of the items in Table 5 were agreed to be problems by the majority of respondents (70-90%), but only four items were identified as major problems by more than half of the respondents as described above.

Table 4: Independent public reporting for hospitals and community health services

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=138)
Support* independent public reporting					
On clinical outcomes for	79	76	88	90	83
Hospitals	79	71	82	86	80
Community health services					

On patient experiences for					
Hospitals	85	89	88	86	87
Community health services	82	89	88	86	86
On quality and safety for					
Hospitals	88	86	88	94	90
Community health services	88	86	88	92	89

*Support or strongly support

Table 5: Potential barriers to implementing independent public reporting

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=138)
Commonwealth-State relationships					
Minor problem	36	39	41	30	36
Major problem	55	39	41	46	46
Reporting that bypasses State/Territory	42	18	47	30	32
Minor problem	39	66	35	42	47
Major problem					
Public understand performance reports	18	53	35	36	36
Minor problem	76	39	41	42	49
Major problem					
Media coverage of performance reports	6	32	29	20	21
Minor problem	85	58	41	54	61
Major problem					
Valid performance measures for:					
Inpatient care					
Minor problem	33	26	53	30	33
Major problem	48	42	24	42	41
Emergency departments					
Minor problem	30	39	47	38	38
Major problem	45	29	24	32	33
Non-acute/community services					
Minor problem	39	26	47	20	30
Major problem	42	55	41	64	54
Consistent data from States/Territories	24	29	12	38	29
Minor problem	70	55	65	50	58
Major problem					
Consistent data from different services	18	26	29	32	27
Minor problem	76	63	53	58	63
Major problem					
Capacity to adjust for community served	21	34	29	36	31
Minor problem	58	42	41	32	42
Major problem					

The new public hospital funding approach

Questions about the detail of activity based funding (ABF) and the new hospital funding approach were asked of respondents from public hospitals, local networks and central agencies but not of community health respondents, consequently the sample size is 100 for these items. The majority supported the use of ABF with special arrangements for rural and specialised facilities (74%) and with incentives that will not lead to decreased quality (85%); however a much smaller majority (56%) supported the use of ABF with incentives which would not lead to increased volume (see Table 6). There was considerable support for the use of ABF for inpatient services (83%) and outpatient and rehabilitation services (72%), but somewhat less support (55%) for its use for emergency services where 27% actually opposed its use (Table 6).

Table 6: Opinions about the use of activity-based funding (Community Health respondents were not asked these questions)

	Public Hospital % (n=33)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=100)
Activity based funding				
For inpatient services				
Support/strongly support	82	82	84	83
Oppose/strongly oppose	6	6	2	4
For outpatient & rehabilitation services				
Support/strongly support	67	71	76	72
Oppose/strongly oppose	9	6	10	9
For emergency services				
Support/strongly support	55	53	56	55
Oppose/strongly oppose	30	24	26	27
In general, with special arrangements for rural/specialised facilities				
Support/strongly support	79	53	78	74
Oppose/strongly oppose	9	6	4	6
With incentives that will not lead to increased volume	48	53	62	56
Support/strongly support	15	35	12	17
Oppose/strongly oppose				
With incentives that will not lead to decreased quality	85	82	86	85
Support/strongly support	6	6	4	5
Oppose/strongly oppose				

The majority of respondents identified the availability of alternatives to acute hospital care and Commonwealth-State agreement on efficient prices and growth in costs as major problems for the implementation of the new hospital funding arrangements, along with valid measures of outpatient and sub-acute activity (see Table 7). These were seen as problems by 80-90% and as major problems by 60-70%. Only a third or fewer thought that the time frame for implementation (34%), valid measures of inpatient activity (30%), payments to local networks directly (27%) and the ability of states to make payments that are not activity-based (26%) were major problems (although these were identified as problems by 56-78%). Respondents also identified a number of additional issues for the implementation of ABF; these included: disadvantage to regional, rural and remote services, disadvantage to aboriginal populations, and a lack of engagement of clinicians and other service providers which was seen as important to efficient service provision.

Table 7: Potential barriers for implementing the new national hospital funding approach (Community Health respondents were not asked these questions)

	Public Hospital % (n=33)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=100)
Valid measures of inpatient activity				
Minor problem	36	47	32	36
Major problem	36	24	28	30
Valid measures of outpatient & sub-acute activity	24	24	22	23
Minor problem	58	65	60	60
Major problem				
The time frame for implementation				
Minor problem	48	47	40	44
Major problem	39	18	36	34
Agreement* on efficient prices				
Minor problem	21	35	26	26
Major problem	73	47	62	63
Agreement* on growth in costs				
Minor problem	27	35	14	22
Major problem	67	53	74	68
Payments directly to Local Networks				
Minor problem	33	18	40	34
Major problem	30	35	22	27
Ability for States to make payments that are not activity-based				
Minor problem	30	29	30	30
Major problem	27	24	26	26
Availability of alternatives to acute hospitals				
Minor problem	15	29	18	19
Major problem	74	65	70	70

*Between the Commonwealth and States/Territories

Medicare Locals

Although 57% of respondents thought that new agencies were required to provide more population focused care and planning, only 24% thought that the role and purpose of Medicare Locals was clear (see Table 8). There was more agreement on the form that Medicare Locals should take in that the majority of respondents (74%) thought that they should have the same boundaries as local hospital networks and few respondents (24%) thought that general practitioners (GPs) should be the lead groups. A substantial minority

thought that community health centres should be the base for Medicare locals (44%) and that they should be part of the same administration as local hospitals (43%). Not surprisingly, there was more support from community health respondents (58%) for the former and more support from public hospital respondents (58%) for the latter.

Table 8: Opinions about the role and development of Medicare Locals

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=138)
Medicare Locals – Agree* with statement					
The role and purpose of Medicare Locals has been made very clear	15	37	24	20	24
New agencies are required to provide more population focused care and planning	58	55	59	58	57
GPs should remain the lead groups in Medicare Locals	36	16	24	22	24
Existing community health centres should be the base for the development of Medicare Locals	45	58	47	32	44
Medicare Locals should be part of the same administration and management as local hospitals	58	32	29	48	43
Medicare Locals should have the same boundaries as Local Hospital networks	82	71	71	72	74

*Agree or strongly agree

Public hospital respondents were not asked about the barriers to establishing Medicare Locals, leaving a sample of 105 community health, local network and central agency respondents. Just over half identified Commonwealth-State relationships, funding models, performance measures and the potential for duplication as major problems for establishing Medicare Locals (see Table 9). While 82-91% saw these as potential problems, only 50-60% saw them as posing major problems. Incorporating Divisions of General Practice, building relationships with other providers and community health services were not seen as

major problems; although they were identified as potential problems by 53-70%, they were only seen as posing major problems by 16-22%.

Table 9: Potential barriers for establishing Medicare Locals (Public Hospital respondents were not asked these questions)

	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=105)
Commonwealth-State relationships and co-operation in policy planning				
Minor problem	26	41	48	39
Major problem	63	53	44	52
Establishing appropriate funding models				
Minor problem	26	24	30	28
Major problem	68	59	54	60
Valid performance measures				
Minor problem	39	41	20	30
Major problem	53	47	70	60
Incorporating current Divisions of GP				
Minor problem	34	6	44	34
Major problem	24	29	12	19
Building relationships with existing providers (allied health & specialists)				
Minor problem	53	53	42	48
Major problem	24	24	20	22
Establishing relationships with existing community health services				
Minor problem	37	53	56	49
Major problem	24	18	10	16
Potential for duplication with Network administration and planning functions				
Minor problem	42	18	30	32
Major problem	50	47	52	50

GP Super Clinics

Less than half of respondents thought that the role and purpose of GP Super Clinics was clear (40%) or that their need had been established (35%), while only 27% thought that they were based on a good funding model (see Table 10). There was some agreement on the form that Super Clinics should take, in that the majority thought that they should incorporate community health services and be made to bulk bill (78% and 69% respectively), while few

thought they should be operated by doctors (9%) or by local hospitals (17%). Just over half (54%) thought that Super Clinics would compete with established primary care providers, while few thought that they would relieve the pressure on hospital emergency departments (34%) or community health services (25%, Table 10).

The questions about barriers to the establishment of GP Super Clinics were not asked of public hospital or community health respondents, leaving only the central agency and local network respondents (n=67). The availability of performance measures was the most frequently identified major problem for the establishment of GP Super Clinics (see Table 11). Few thought that ongoing funding, attracting providers to work in Super Clinics or building relationships with existing providers would be major problems; although 60-70% identified these as potential problems, only 28-30% saw them as major problems.

Table 10: Opinions about the role and impact of GP Super Clinics

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=138)
GP Super Clinics - Agree* with statement					
The role and purpose of Super Clinics has been made very clear	21	53	35	44	40
The need for Super Clinics has been clearly established	33	34	41	34	35
Super Clinics will relieve the pressure on hospital emergency departments	33	26	35	40	34
Super Clinics will relieve the pressure on community health services	21	16	29	32	25
Super Clinics will compete with established GPs and other primary care providers	52	55	65	52	54
Super Clinics should only be operated by doctors or doctor groups	6	3	18	12	9
Super Clinics should be operated by local hospitals	30	11	12	16	17
Super Clinics should incorporate community health services	82	79	65	78	78
Super Clinics should be required to bulk bill	73	76	53	66	69
The mix of fee for service and existing State/Territory funding is a good funding model	9	34	35	30	27

*Agree or strongly agree

Table 11: Potential barriers for establishing GP Super Clinics (public hospital and community health respondents were not asked these questions)

	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=67)
Ongoing funding			
Minor problem	35	34	34
Major problem	41	26	30
Valid performance measures			
Minor problem	29	26	27
Major problem	65	52	55
Attracting providers to work in Super Clinics			
Minor problem	35	40	39
Major problem	47	22	28
Building relationships with existing providers (allied health and specialists)			
Minor problem	41	32	34
Major problem	35	26	28

Funding approaches

Respondents were asked their opinions of some alternative funding approaches to ABF which are reported in Table 12. Only 29% agreed with using risk adjusted capitation budgets for local networks (only 18% of local network administrators), although there was somewhat more support (47%) for a pay for performance system. The majority of respondents (79%) thought that more flexible funding streams were required to encourage better care coordination; support for the latter was highest among community health respondents (92%) and lowest among public hospital respondents (67%, Table 12). Despite considerable support for the use of ABF (particularly for inpatient services, see Table 6), only 36% of respondents agreed that ABF is the best way to improve hospital efficiency. Just under half of respondents (46%) thought that ABF for hospitals would place more demand on community services, although more than half (55%) of public hospital and community health respondents thought this would be the case (Table 12). ABF for

community services was thought to be good for the services by 44% of respondents (45% of community health respondents).

Table 12: Opinions about funding approaches

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=138)
Funding – Agree* with statement					
Activity based funding is the best way to make hospitals more efficient	27	39	35	40	36
Activity based funding for hospitals will place more demand on community services	55	55	41	34	46
Activity based funding for community services would be good for the services	52	45	41	40	44
Instead of activity based funding, we should move to pay for performance and stronger incentives for outcomes	48	42	59	46	47
Instead of focusing on hospitals, we should move to more flexible funding streams that will encourage more coordinated care	67	92	76	78	79
Instead of activity based funding, we should move to fund the Local Networks with risk adjusted capitation budgets to purchase care	33	34	18	26	29
The lack of community care or alternatives to acute hospitals impacts on community health services	79	95	88	88	88

*Agree or strongly agree

Commonwealth-State/Territory funding arrangements

Five of the six questions about Commonwealth-State funding arrangements were not asked of the community health respondents; consequently the sample size is 100 for these five

items. Most respondents (82%) thought that there should be agreed upon funding shares between the Commonwealth and States (see Table 13). However, just under half thought that the Commonwealth should play a greater role in financing care; 44% thought that the agreed upon share should have been for all costs not just growth in costs, while 45% thought that the Commonwealth Government should take on full responsibility for public hospital funding and 49% for funding all health care (Table 13). There was even less support (21%) for staying with the original 60:40 Commonwealth share of public hospital funding. More than half of all respondents (n=138) thought that the Commonwealth should have kept its commitment to fund all primary care and community health services.

Table 13: Views on Commonwealth-State/Territory funding arrangements (Community Health respondents were not asked five of the six questions)

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=138)
Agree* with statement					
The Commonwealth should have kept its commitment to 100% funding of primary care and community services	52	58	71	58	58
					(n=100)
There should be agreed upon funding shares for the Commonwealth and States	85	-	76	82	82
The Commonwealth should have agreed to a 50:50 share for all costs, not limited to the growth in costs	36	-	59	44	44
The Commonwealth should have stayed with the 60:40 share of public hospital funding	30	-	18	16	21
All responsibility for all public hospital funding should be moved to the Commonwealth	45	-	35	48	45
All responsibility for all health care funding should be moved to the Commonwealth	48	-	47	50	49

*Agree or strongly agree

Expectations for success of the reform strategies

Almost half of the respondents thought that the reforms would strengthen the Commonwealth's role in improving hospital performance (46%), would lead to better decision making which considers the local context (49%) and would improve health service delivery (49%), see Table 14. Forty-one percent thought the Commonwealth would have a stronger role in policy for Community Health services, while only 19% were confident that the states would be able to manage the health system effectively, and most importantly, very few respondents expect the new arrangements to remove the 'blame game' between the Commonwealth and States/Territories (Table 14).

Table 14: Opinions about the potential impacts of the health reform initiatives

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=50)	Total % (n=138)
Success of reforms - Agree* with statement					
By considering the local context, Local Networks will ensure better decision making	55	47	65	42	49
The combination of activity based funding and performance reporting will improve health service delivery	42	53	53	50	49
The Commonwealth will play a much stronger role in improving hospital performance	58	45	53	36	46
The Commonwealth will have a much stronger role in policy for community health services	39	47	47	36	41
The new arrangements will remove the 'blame game' between the Commonwealth and States/Territories	18	13	0	2	9
The States and Territories will be able to manage the health system effectively	21	24	24	12	19

*Agree or strongly agree

Other potential reform strategies and issues

Respondents were also asked their opinions about a range of other strategies for reform which are reported in Table 15. The most popular strategies included financing models that meant funds could be moved between hospitals, primary care and other services (supported by 88%), more investment in developing evidence (supported by 82%), the use of private facilities to ease pressure on the public sector (supported by 64%) and the redesign of the extended Medicare Safety Net (supported by 63%). The use of private facilities for public patients was most popular among public hospital respondents (supported by 76%) and least popular among central agency/bureaucracy respondents (supported by 57%). While just over half of respondents (55%) supported allowing private agencies to contract for public patients and encouraging the uptake of private health insurance, there was relatively little support (31%) for giving private insurers a strong role as purchasers of health care. Encouraging the uptake of private insurance was most popular among public hospital respondents (supported by 79%) and least popular among central agency/bureaucracy respondents (supported by 45%) and local network respondents (supported by 47%). Almost half of the respondents (49%) supported the use of patient co-payments.

Table 15: Opinions about other potential strategies for reform

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=49)	Total % (n=137)
Co-payments to encourage patients to seek more efficient providers	64	45	41	45	49
Support/strongly support	12	21	29	24	21
Oppose/strongly oppose					
Re-design of the Extended Medicare Safety Net					
Support/strongly support	73	66	65	53	63
Oppose/strongly oppose	6	3	6	0	3
More flexible funding models - funds moved across hospitals, primary care, community care and other services	82	92	94	88	88
Support/strongly support	3	0	0	4	2
Oppose/strongly oppose					
Use of private hospitals/other private facilities to ease pressure on the public sector					
Support/strongly support	76	61	71	57	64
Oppose/strongly oppose	9	18	6	20	15
Allowing private agencies to contract for public patients					
Support/strongly support	64	53	59	51	55
Oppose/strongly oppose	21	26	24	27	25
Encouraging the take-up of private insurance					
Support/strongly support	79	53	47	45	55
Oppose/strongly oppose	3	21	29	24	19
Giving private insurers a strong role as purchasers of health care					
Support/strongly support	39	32	24	29	31
Oppose/strongly oppose	18	47	59	37	38
More investment in developing the evidence for health care reforms	82	92	88	71	82
Support/strongly support	6	3	0	8	5
Oppose/strongly oppose					

Almost all respondents (over 90%) thought that aged care, mental health services, dental services and care for people with disabilities were all sectors with problems that needed to be addressed by the reform process (see Table 16). A majority of respondents also thought that improving lifestyles by investing in prevention (83%) and the funding and organisation

of specialists (66%) were important issues for the reform process (Table 16), while half of respondents also thought that the subsidy for private health insurance was a problem that needed to be addressed. Only 34% were concerned about the funding of private hospitals.

Table 16: Other issues related to health system reform

	Public Hospital % (n=33)	Community Health % (n=38)	Admin Local Network % (n=17)	Central Agency /Bureaucracy % (n=49)	Total % (n=137)
Was the issue a problem before reform?					
The subsidy for private health Insurance	42	47	53	55	50
Yes-important to reform	0	5	6	0	2
Yes-but not important					
The funding of private hospitals					
Yes-important to reform	30	42	41	29	34
Yes- but not important	3	5	0	4	4
Funding for & organization of specialists	61	61	76	71	66
Yes-important to reform	0	0	0	2	1
Yes- but not important					
Improving lifestyles and investing in prevention					
Yes-important to reform	67	100	71	86	83
Yes- but not important	3	0	0	0	1
Did the sector have problems before reform?					
Aged care					
Yes-important to reform	94	92	100	88	92
Yes- but not important	0	0	0	2	1
Care for people with disabilities					
Yes-important to reform	100	92	88	88	92
Yes- but not important	0	0	6	2	1
Mental health services					
Yes-important to reform	97	100	94	88	94
Yes- but not important	0	0	0	4	1
Oral and dental health services					
Yes-important to reform	94	95	82	88	91
Yes- but not important	0	0	0	2	1

Discussion

In sum, this survey provides some very clear messages

- Change was needed in the Australian health system,
- There is strong support for the general direction of the reforms,
- But the change embodied in the National Health Reform Agreement will not be enough

Of our respondents, 9 in 10 agreed that fundamental change or complete rebuilding was needed. Fewer of our sample considered the system in need of only minor change, compared to Australian primary care physicians (23%) (14), and Australian adults generally (24%) (15), as reported from recent similar surveys. This is consistent with the view that the most pressing problems in the Australia health care system concerned public hospitals.(16) Few of our respondents thought that the current reforms were sufficient to provide the required improvements; nearly two thirds supported the need for further reform.

However, support for reform in general does not necessarily translate into support for a particular direction or policy. Views about the individual reform elements were mixed.

- There was strong support for public reporting of performance
- But continuing concerns about data consistency and media interpretation

Support for activity based funding of public hospital services was more cautious.

- There was good support for the introduction of ABF
- Particularly if care is taken not to set disincentives for quality
- There was concern about whether some population groups would be disadvantaged
- And few think this is the best way to make hospitals more efficient

- Most think more flexible funding approaches are needed

Nonetheless, 50% of respondents thought the combination of ABF and performance reporting would improve service delivery. The same proportion also felt that the new Local Hospital Networks would lead to better decision making. Interestingly, there was strong support for further reforms to health financing to provide more flexible funding and coordinated care.

Our respondents saw several barriers to the implementation of the reforms. The schedule for implementation was seen as ambitious, with 77% responding that the reforms were unlikely to be implemented as planned. Other issues identified as major problems were the availability of alternatives to acute hospital care, valid measures of activity and performance particularly in outpatient and community services, and establishing appropriate funding models for Medicare Locals. Almost two-thirds of our respondents felt they were well informed, with GP Super Clinics and hospital funding being the reform strategies on which most were well informed. This could be due to the concept of and commitment to Super Clinics having preceded the other reform strategies; and that some form of ABF was already operating in most of the States and Territories. Still half or more of the respondents did not feel well informed about any of the major parts of the reform package, suggesting that ensuring adequate and accurate information reaches those involved should be addressed.

There were some important areas for concern.

- The role of Medicare Locals and GP Super Clinics was unclear
- There were mixed views about the likely success of reforms
- Only one in ten thought this would end the ‘blame game’
- Two in ten thought States and Territory would be effective system managers

There are limitations to surveys such as this. The sample size is relatively small, but compares well with similar surveys, such as Stremikis et al,(13) with 201 respondents, and Blendon et al,(17) with 100 respondents. The anonymous responses result in little information on which to judge the representativeness of the survey, but were expected to improve the response rate.

To date the literature, even in peer reviewed journals, has provided commentary on the design of the reforms and the challenges in implementation based on the opinion of individuals with health policy and health system expertise; for examples see Stoelwinder,(18) Simpson and Lennox,(19) Podger et al,(20) and Kidd.(21) There is little information available on which to monitor the impact and implementation of reforms. This survey contributes to that information gap, by seeking opinions from key managers and opinion leaders. These are the managers who are responsible for implementing and responding to many aspects of the reforms, and hence their views and reactions are critical influences on the success of reforms. This information cannot replace rigorously designed and well conducted evaluations of the reforms, but it can add to it.

Surveys such as this are cross-sectional by nature, which means the results provide a 'snapshot' of views. This survey was fielded at the end of 2011; and there have been notable developments since then. The Independent Hospital Pricing Authority has produced its second annual price determination, developed a Pricing Framework, and embarked on a major work program for refining its approach and developing classifications and costing data.(22) The National Health Performance Authority has taken responsibility for the MyHospitals website;(23) and released a major report on primary care.(24) Medicare Locals are now operating across the country. We would expect to see quite different results if the

survey were repeated now. Further surveys can provide a valuable means for assessing the progress of reform implementation.

References

1. Rudd K. Kevin Rudd's *Better Health Better Hospitals Speech*. Transcript of speech delivered to the National Press Club on 3rd March 2010, published online by The Australian13th July 2010. Available from: http://www.theaustralian.com.au/politics/kevin-rudds-better-health-better-hospitals-speech/story-e6frgczf-1225836509805.

2. Council of Australian Governments. N*ational Health Reform Agreement*. Canberra: Australian Government; 2011; Available from: http://www.federalfinancialrelations.gov.au/content/npa/health_reform/national-agreement.pdf.

3. Fulop L, Day GE. *From leader to leadership: clinician managers and where to next?* Australian Health Review. 2010;34(3):344-51.

4. Anonymous. *National health reforms: An update from the Australian department of health and ageing* [conference abstract].RACP Future Directions in Health Congress 2012. Internal Medicine Journal. 2012;42(Supplement 2):32-3.

5. Martinussen PE, Magnussen J. *Resisting market-inspired reform in healthcare*: The role of professional subcultures in medicine. Social Science & Medicine. 2011;73(2):193-200.

6. Arya D. *So, you want to lead a transformational change!* Asia Pacific Journal of Health Management. 2012;7(2):8-14.

7. Hall J, Fiebig D. *Private health insurance in Australia*. In: Thomson S, Mossialos E, Evans R, editors. Private health insurance and medical savings accounts: lessons from international experience: Cambridge University Press; Forthcoming.

8. House of Representatives Standing Committee on Health and Ageing. *The Blame Game: Report on the Inquiry into Health Funding*. Canberra: Commonwealth of Australia; 2006.

9. Productivity Commission. *Review of National Competition Policy Reforms*. Report no. 33. Canberra2005.

10. National Health and Hospitals Reform Commission. *A Healthier Future For All Australians – Final Report June 2009*. Canberra: Australian Government; 2009.

11. Australian Government. *A National Health and Hospitals Network for Australia's Future - Delivering the Reforms*. Canberra: Australian Government; 2010.

12. Grbich C. *Qualitative Research in Health: An Introduction.* Sydney: Allen & Unwin; 1999.

13. Stremikis K, Davis K, Nuzum R. *Health Care Opinion Leaders' Views on Health Reform, Implementation, and Post-Reform Priorities.* Data Brief. New York: The Commonwealth Fund, 2010 1387 Vol. 29.

14. Schoen C, Osborn R. *The Commonwealth Fund 2009 International Health Policy Survey of Primary Care Physicians in Eleven Countries*. New York: The Commonwealth Fund, 2009.

15. Commonwealth Fund. T*he Commonwealth Fund 2010 International Health Policy Survey in Eleven Countries*. Chartbook. New York: Commonwealth Fund, 2010.

16. Hall J. *Designing the structure for Australia's health system*. Occasional Paper No. 1: Academy of Social Sciences in Australia; 2010.

17. Blendon RJ, Schoen C, DesRoches CM, Osborn R, Zapert K, Raleigh E. *Confronting Competing Demands To Improve Quality: A Five-Country Hospital Survey. Health Affairs*. 2004;23(3):119-35.

18. Stoelwinder JU. *Final report of the National Health and Hospitals Reform Commission: will we get the health care governance reform we need?* Medical Journal of Australia. 2009;191(7):387-8.

19. Simpson J, Lennox N. *Enabling health reform*. Health Issues. 2011;105(Summer 2011).

20. Podger A, Gillespie J, Beaton A, Leeder S, Dwyer J, Martins J, et al. Commentary. Asia Pacific Journal of Health Management. 2010;5(1):17-24.

21. Kidd MR. *General practice and the Australian Government's National Health Reform Plan*. Medical Journal of Australia. 2010;193(2):71-4.

22. Independent Hospital Pricing Authority. Multiple reports. Available from: http://www.ihpa.gov.au/.

23. National Health Performance Authority. MyHospitals website. Available from: http://www.myhospitals.gov.au/.

24. National Health Performance Authority. *Healthy Communities: Australians' experience with primary health care in 2010–11:* Available at www.nhpa.gov.au/; 2013.