National Health and Hospital Networks, COAG and Mental Health Reform

Local Hospital Networks

Position Paper

Local Hospital Networks (LHNs) will be the direct managers of single or small groups of public hospital services and their budgets through a professional Governing Council, in order to devolve operational management for public hospitals and accountability for delivery to the local level. They will be held directly accountable for hospital performance. Local Hospital Networks will engage with the local community and local clinicians to incorporate their views into the day-to-day operation of hospitals, especially regarding the quality and safety of patient care. Local Hospital Networks will work with new primary health care organisations to support more integrated care and help ensure patients experience smooth transitions between sectors of the health system.

COAG Communiqué, 20 April 2010

Introduction

The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians. The membership of the MHCA includes national organisations of mental health service consumers, carers, special needs groups, clinical service providers, community and private mental health service providers, national research institutions and state/territory peak bodies.

In April 2010 at the Council of Australian Governments (COAG) meeting, the Federal Government won the support of all states/territories (with the exception of WA) for the National Health and Hospitals Network (NHHN) Agreement.

This Agreement has three primary objectives:

- Reforming the fundamentals of our health and hospital system, including funding and governance, to provide a sustainable foundation for providing better services now and in the future.
- Changing the way health services are delivered, through better access to high quality integrated care designed around the needs of patients, and a greater focus on prevention, early intervention and the provision of care outside of hospitals.
- Providing better care and better access to services for patients right now, through increased investments to provide better hospitals, better infrastructure, and more doctors and nurses.

The establishment of “Local Hospital Networks” (LHNs) with “local community Boards” was a key element of this Agreement for Australia’s 780 public hospitals.

Of the $7.4 billion announced in the COAG Agreement and the 2010 Federal Budget for health reform, only $181.3 million over the four years was specifically directed to mental health. Of this, a mere $115 million was identified by the Government as new funding – the remainder either being redirected or restorative funding. This represented less than 1.6% of all new healthcare funding.

In February 2011, concerns from a number of state governments relating to the proposed Commonwealth take over of funding resulted in a new Agreement between all state and territory governments. Despite this new Agreement, the situation for mental health remains unchanged. Moreover, changes in government at the state and territory level continue to threaten commitments enshrined in these two Agreements and further perpetuates a state of unease and uncertainty within the Australian health and mental health sectors in relation to these reforms.

This paper aims to summarise the commitments made by governments relating to the establishment of LHNs and identify the key issues as they pertain to the mental health sector. The paper is one of a series of papers published by the MHCA to be considered by members as part of a sector-wide response in the lead up to the 2011 Federal Budget and the next COAG meetings.

Issues for the Mental Health Sector

Key Issues for the Mental Health Sector in relation to LHNs

1. Under the COAG Agreements between states/territories and the Commonwealth, some provisions for transitional arrangements for alcohol and drug and mental health services are being developed.
2. There are also principles set out in the COAG National Agreement relevant to any transition process. These state that services should:
   - be shaped around the health needs of individual patients, their families and communities
   - focus on the prevention of disease and injury and the maintenance of health, not simply the treatment of illness
   - supportive of an integrated approach to the promotion of healthy lifestyles, prevention of illness and injury, and diagnosis and treatment of illness across the continuum of care
   - provide timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country.

   It is not clear if these principles have been applied in the decisions made by states/territories to date.
3. The tenets and values underpinning recovery practice in the community mental health sector do not sit comfortably with the bio-medical philosophy and orientation of hospitals. The members of LHN Boards are unlikely to be familiar with, and therefore less supportive of, investment in community managed mental health services.
4. In addition, it is now clear that states/territories have retained full control over hospitals through state legislation and bureaucratically controlled structures. In a number of jurisdictions it is becoming apparent that all community mental health services, including those run by community organisations, will be aligned structurally and administratively to LHNs. Only some limited general counselling services within public community health services are likely to transition to a Medicare Local.
5. Since the inception of the National Mental Health Plan in 1992, the investment by state and territory governments in community managed mental health services has remained minimal. Only Victoria has maintained investment at 11-14% of total mental health expenditure over most of this period. The 2010 National Mental Health Report[1] shows that just 8.3% of all mental health funding by state/territory governments is directed to community organisations and most growth occurred after 2005. With the shift in decision-making from central state mental health directorates to LHN Boards, and mental health often marginalised in debates regarding resource allocations, there is a real danger of further decline in the allocation of funding for mental health for both public and community organisations.
6. Rolling out a national efficient price for the thousands of procedures and services delivered in hospitals is likely to take some years (as it has in Victoria for a state-wide efficient price and other jurisdictions overseas) and it is unlikely during this period of learning that the National Pricing Authority will call a LHN to account for higher costs for particular services.

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[1] Department of Health and Ageing (2010), *National Mental Health Report 2010*. Canberra.

7. Internationally, there is a trend away from case-mix or activity based costing in health services. Australia appears to be adopting a model of health funding that is losing favour in other advanced economies.[2]
8. For many community mental health organisations the complexity of relationships with funding bodies will increase with the introduction of LHNs and Medicare Locals. The likely future is that community organisations will be seeking and receiving funding from LHNs, Medicare Locals, state departments (for state-wide services) and Federal Government agencies. This will consume more scarce resources in project/program administration.

A Mental Health Sector-wide Position on Local Hospital Networks

These issues or principles are proposed to underpin a whole of sector advocacy position in relation to the NHHN Reforms relating to LHNs.

Position: The integrity of funding streams needs to be retained

- LHN governance models need to retain control and quarantining of funding.
- Mental health funding needs to be controlled by mental health. This would ensure mental health core and project funding is not blocked or diverted to non-mental health expenditure.
- Further dividing up components of care will make the system vulnerable to agencies "cherry picking" mental health clients putting undue stress/cost on other parts of the system.

Position: Services need to be integrated

- There is a need to retain and build integration of hospital and community services. Any realignment should not separate community mental health or alcohol and other drug inpatient structures – one integrated 'whole' service: specialist services covering the continuum of care for appropriate management of patients/clients.

Position: Disruption to client flow must be avoided

- There is concern about the maintenance of existing acute referral pathways and how control of governance and funding can be maintained to ensure an organised patient flow.
- Cross border arrangements for best care need to be considered, e.g. networking Albury/Wodonga, Dareton with Mildura etc., for acute care conditions.

Acknowledgements

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[2] Garcia Armesto, S., Medeiros, H. and Wei, L. (2008). *Information availability for measuring and comparing quality of mental health care across OECD countries*. Organisation for Economic Development and Cooperation (OECD), Paris.