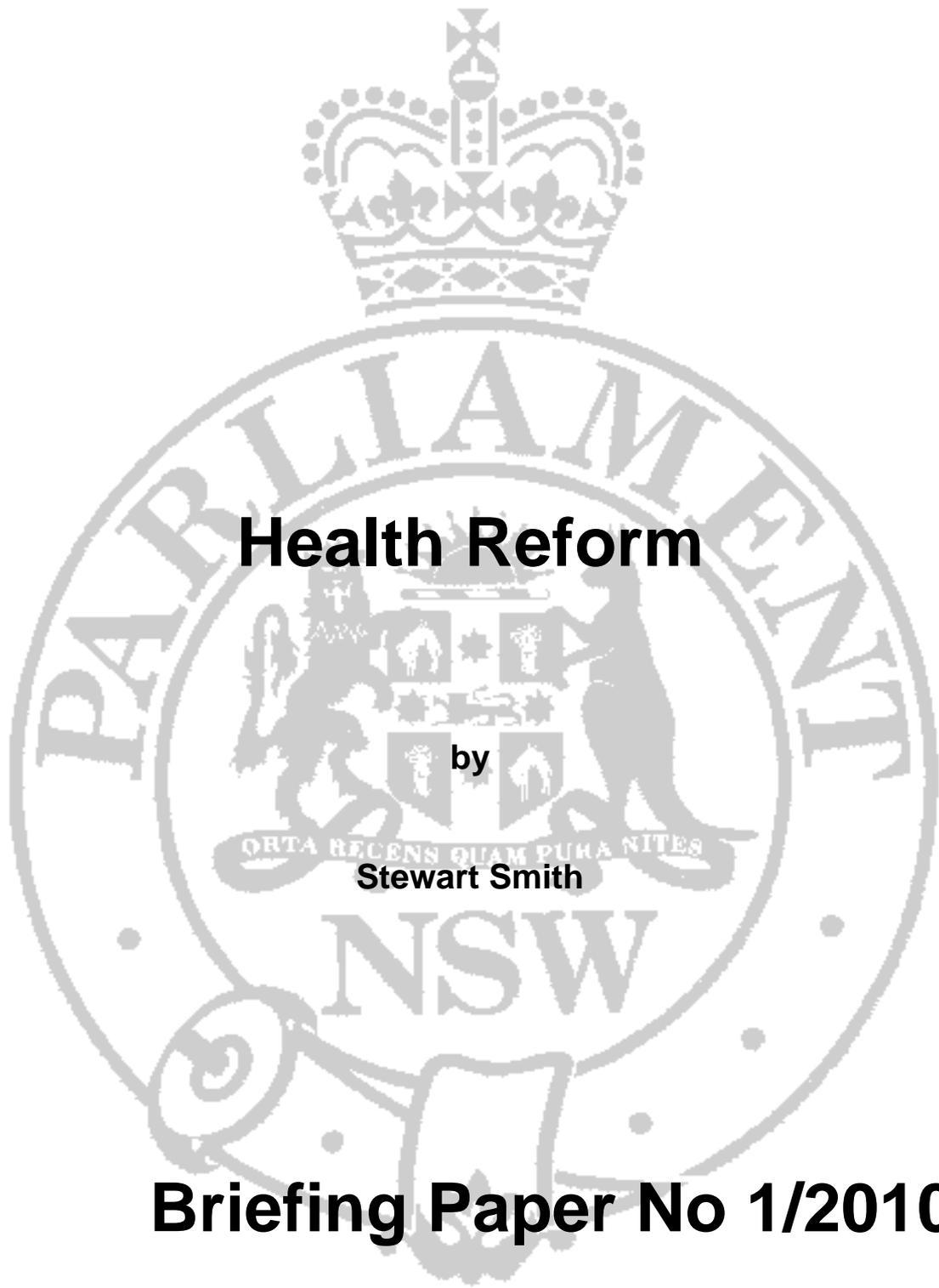


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Health Reform

by

Stewart Smith

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Health Reform

by

Stewart Smith

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SUMMARY

In 2006 the NSW Parliamentary Library published a Briefing Paper titled *Commonwealth – State Responsibilities for Health: Big Bang or Incremental Reform*. Some four years later, in March 2010 the Federal ALP Government released its health reform agenda, and has clearly chosen the ‘Big Bang’ reform option.

The Federal Government proposes fundamental changes to the governance and financing of health, including the establishment of Local Hospital Networks and governing councils. This paper focuses on those issues most relevant to the major reforms proposed by the Commonwealth, namely governance and funding of the health system.

NSW Governance of the Health System

Through its Area Health Services (AHSs), NSW Health provides a vast range of inpatient, outpatient and ambulatory care services. NSW Health is the consolidated parent which controls eight AHSs. Area Health Services are statutory corporations constituted under the *Health Services Act 1997*, and each are principally concerned with the provision of health services to residents within a defined geographical area.

Prior to reforms in 2005, there were 17 Area Health Services across NSW. Prior to 2005 each of the AHSs had a chief executive officer and a board of directors. The CEO reported to both the Director-General of NSW Health and the Chairman of the AHS board. AHS boards over-saw the direction of the health operations within their geographic region. Responsibility for the management of day to day operations was vested directly with the CEO.

A 1998 review of the health system by IPART identified that there was a lack of clarity in the roles of the AHS in relation to NSW Health. IPART noted the progressive centralisation of decision making by NSW Health. It stated that NSW Health had developed a tendency to review and approve all the commercial decisions of each AHS. In contrast, AHSs tended to focus excessively on balancing budgets, meeting waiting list targets and avoiding events which would cause adverse publicity.

A subsequent 2003 IPART report focussed on the same themes as in 1998, and concluded that little had changed. It also recommended a national inquiry under the auspices of COAG to address Commonwealth and State funding and division of responsibilities to better coordinate health care delivery.

The two IPART reports commented on the tussle of health governance between the 17 Area Health Boards on the one hand, and the central control of the Department of Health on the other. The Government’s response was firmly in favour of centralising control.

With the passage of the *Health Services Amendment Bill 2004*, the State ALP Government reduced the number of Area Health Services from 17 to 8. At the same time, the Act fundamentally changed governance arrangements. Area Health Boards were abolished, with Area Health Services being controlled and managed

by a chief executive, answerable to the Director-General, and in turn the Minister for Health. The creation of fewer, larger Area Health Services, and the abolition of their respective boards, was not supported by the Opposition.

On 29 January 2008 Peter Garling SC was appointed by the Governor of NSW to conduct a Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals. This followed several tragic incidents, including the death of 16 year old Vanessa Anderson at Royal North Shore Hospital. The Garling Report was three volumes and some 1200 pages long. This review of the report focuses on those issues relevant to this paper, in particular governance of the hospital system.

Garling noted that he had received a huge number of submissions highlighting that there had been a shift from clinical governance of corporate matters to corporate governance of clinical matters. He reviewed the Area Health Service structure, and noted the 2005 reforms. Garling concluded the present governance structure, and other factors, have caused a serious loss of morale in senior medical staff and hospital management.

Garling revisited some of the themes that emerged from the IPART reports. For instance, he noted that the solution to the above identified problems is to devolve decision-making capacity to health services. However, he identified that there is a lack of clarity about the extent of authority of general managers of hospitals, and that this needs to be clearly defined.

Garling concluded that governance needs to be devolved to a more local level by:

- greater delegation to hospital and unit or ward level;
- greater involvement of clinicians in management decisions; and
- strengthening the structures, including committee structures at hospital level, for communication between management and clinicians.

The NSW Government response to this issue was the establishment of Hospital Clinical Councils.

National Health and Hospitals Reform Commission

On 25 February 2008 the Commonwealth Government announced the establishment of the National Health and Hospitals Reform Commission. The Commission issued a final report in June 2009.

The Commission noted that the case for health reform is compelling. It noted that while the health system has many strengths, it is a system under growing pressure. Furthermore, it is fragmented with a complex division of funding responsibilities and performance accountabilities between different levels of government. The report identified actions that can be undertaken by governments to reform the health system under three reform goals:

- Tackling major access and equity issues that affect health outcomes for people now;
- Redesigning our health system so that it is better positioned to respond to emerging challenges; and
- Creating an agile and self-improving health system for long-term sustainability.

The Commission's Final Report included 123 recommendations. In its work the Commission considered options for governance reform. It recommended:

1. The Commonwealth Government to be responsible and accountable for the strategic direction, planning and public funding of primary health care. The Commonwealth Government assumes full responsibility for primary health care services.
2. The Commonwealth Government assume full responsibility for providing universal access to basic dental care.
3. The Commonwealth Government assume full responsibility for public funding of aged care services.
4. The Commonwealth Government assume full responsibility for the purchasing of all health services for Aboriginal and Torres Strait Islander people.

In regard to the funding of public hospitals and health care services, the Commission recommended that the Commonwealth Government should:

- pay 100 per cent of the efficient cost of public hospital outpatient services using an agreed casemix classification and an agreed, capped activity-based budget;
- pay 40 per cent of the efficient cost of every public patient admission to a hospital, subacute or mental health care facility and every attendance at a public hospital emergency department; and
- pay 100 per cent of the efficient cost of delivering clinical education and training for health professionals across all health service settings, to agreed target levels for each state and territory.

Following the release of the National Health and Hospitals Reform Commission report, the Commonwealth government began a period of consultation around Australia. The Commonwealth subsequently released its health reform plan on 3rd March 2010, entitled: [A National Health and Hospitals Network for Australia's Future](#). The Commonwealth proposes radical reform to the governance of the Australian health system.

The Commonwealth Proposal

The Commonwealth stated: "To overcome fragmentation, blame shifting and cost shifting across the health system, the Commonwealth will move to ensure that one level of government has majority funding responsibility for the hospital system."

In a fundamental change to hospital funding arrangements, the Commonwealth will increase its funding contribution for public hospital services to:

- 60 per cent of the efficient price of every public hospital service provided to public patients;
- 60 per cent of recurrent expenditure on research and training functions undertaken in public hospitals;
- 60 per cent of capital expenditure, to maintain and improve public hospital infrastructure;
- over time, up to 100 per cent of the efficient price of 'primary health care equivalent' outpatient services provided to public hospital patients.

The Commonwealth Government will take full responsibility for funding all general practice and primary health care services in Australia. The Government noted that the importance of this reform is that by taking funding and policy responsibility for all primary health care services, and 60 per cent of public hospital funding, the Commonwealth will have the ability to drive 'allocative efficiency' across the system. This will encourage integrated care and ensure patients are cared for in the most appropriate and efficient setting.

Monitoring and reporting will be undertaken on the performance of the whole health system and that of individual hospitals.

The Commonwealth will require the States to introduce Local Hospital Networks to run small groups of hospitals. The Networks are to be established as separate state statutory authorities, and comprise between one and four hospitals. Local Hospital Networks will have a professional Governing Council and Chief Executive Officer (CEO), who will be responsible for delivering agreed services and performance standards within an agreed budget. Each Network's CEO will be appointed by the Council and accountable to the Council.

States will continue to be responsible for meeting the remaining costs of public hospital services, including meeting any costs over and above the efficient price, as well as the remainder of teaching, research and capital costs. State governments will also continue to own public hospital assets. They will work with Local Hospital Networks to determine the range and number of public hospital services to be provided within their jurisdiction and to be responsible for all aspects of industrial relations policy and employment of the public hospital workforce.

The Commonwealth supports the delivery of free public hospital services through block grant funding paid to the states. Each State then determines funding for individual hospitals. The Commonwealth proposes to fund Local Hospital Networks directly for each service provided to a patient, through activity based funding. An independent umpire is to be established to set an efficient price for each procedure. It will finance these changes by dedicating around one-third of total GST revenue — all of which is currently provided to the states — directly to health and hospital services across the country.

In response to the Commonwealth proposals the NSW Premier has welcomed the potential of the reforms, but wants to ensure that NSW communities will be protected. The State Government announced a three-step process it intends to follow before responding to the Commonwealth's proposal, including the publication of a discussion paper and the creation of an on-line forum.

If COAG cannot agree on the reforms, the Commonwealth has stated that it will seek a mandate from the Australian people to implement the Plan.

1.0 INTRODUCTION

In 2006 the NSW Parliamentary Library published a Briefing Paper by Gareth Griffith titled: [Commonwealth – State Responsibilities for Health: Big Bang or Incremental Reform](#). Some four years later, in March 2010 the Federal ALP Government released its health reform agenda, and has clearly chosen the ‘Big Bang’ reform option. The Federal Government proposes fundamental changes to the governance and financing of health, including the establishment of Local Hospital Networks and governing councils. Historically, the Federal Government has provided block health funding to the States. In a significant departure from this practice, it is proposed that the new Networks will be paid directly by the Commonwealth for services provided to patients.

The 2006 Briefing Paper provides a comprehensive account of the Australian health system, including a review of systemic and operational issues. Since then, several important inquiries, both state and national, have occurred. This paper focuses on those issues most relevant to the major reforms proposed by the Commonwealth, namely governance and funding of the health system.

1.1 The Structure of the Health Sector

The main features of Australia’s health system are:

- Universal access to benefits for privately provided medical services under Medicare, which are funded by the Australian Government, with co-payments by users when the services are not bulk-billed.
- Eligibility for public hospital services, free at the point of service, funded jointly by the states and territories and the Australian Government.
- Private hospital activity largely funded by private health insurance, which in turn is subsidised by the Australian Government through the 30–40% rebates on members’ contributions to private health insurance.
- The Australian Government, through its Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme, subsidises a wide range of pharmaceuticals outside public hospitals for the general public and eligible veterans, respectively.
- The Australian Government provides most of the funding for health research.
- State and territory health authorities are primarily responsible for public hospitals, mental health programs, the transport of patients, community health services, and public health programs and activities (for example, health promotion and illness prevention).
- Individuals primarily spend money on medications, dental services, aids and appliances, medical services, other health practitioner services and hospitals.¹

¹ Australian Institute of Health and Welfare Expenditure, *Health Expenditure Australia 2007-08*. September 2009.

2.0 THE GOVERNANCE OF THE NSW HEALTH SYSTEM

This section reviews governance reform of the State health system. As will be seen later in this paper, present day governance arrangements are to be truly challenged by Commonwealth proposals.

Through its Area Health Services (AHSs), NSW Health provides a vast range of inpatient, outpatient and ambulatory care services including community care, mental health services, mothercraft centres, immunisation programs, dental clinics, methadone programs, diabetes centres, and health promotion services. NSW Health is the consolidated parent which controls eight AHSs.

Area Health Services are statutory corporations constituted under the *Health Services Act 1997*, and each are principally concerned with the provision of health services to residents within a defined geographical area.

Prior to reforms in 2005, there were 17 Area Health Services across NSW. Prior to 2005 each of the AHSs had a chief executive officer (CEO) and a board of directors who were appointed by the Governor on recommendation of the Minister for Health. The CEO reported to both the Director-General and the Chairman of the AHS board. AHS boards over-saw the direction of the health operations within their geographic region. Responsibility for the management of day to day operations was vested directly with the CEO. It is useful to review the lead up to these amalgamations in 2005 and subsequent events, in an effort to garner useful lessons for contemporary reform.

2.1 The 1998 IPART Review

The Independent Pricing and Regulatory Tribunal (IPART) performed two reviews of the NSW Health System, one in 1998 and another five years later in 2003.

In 1998 IPART identified that there was a lack of clarity in the roles of the AHS in relation to NSW Health. AHS have combined the roles of funding and operating facilities and caring for health needs of the local community. While the role of NSW Health was essentially one of strategic system responsibility, IPART noted that the media and community seemed to be moving NSW Health to adopting a role of being accountable for the outcome of every patient in the public system. This system-wide accountability has seen Health retract some of the management autonomy of the AHSs. However, IPART concluded that the net outcome of these multiple roles may be confused, rather than better, accountability and impediments to the AHS pursuing innovative approaches to delivering better health services.

IPART noted the progressive centralisation of decision making by NSW Health. It stated that NSW Health had developed a tendency to review and approve all the commercial decisions of each AHS. In contrast, AHSs tended to focus excessively on balancing budgets, meeting waiting list targets and avoiding events which would cause adverse publicity. This excessive attention to net cash, waiting list and avoiding 'headline' items came at a cost of a reduced focus on efficiency, quality and performance.

The 1998 IPART review canvassed the options of retaining the AHS structure,

amalgamating some of them, or having one central body administering the 223 public hospitals in the State. It noted that proponents of the AHS management structure cited several advantages over a centralised model including:

- geographically based AHSs result in managements having a closer affinity for conditions and the faster resolution of any problems in local facilities;
- the scale of the AHS structure is large enough to exploit economies of scale, yet small enough to avoid diseconomies likely under a centralist model;
- the practicalities of monitoring the performance and budget compliance of 223 public hospitals are difficult for one central body.

In contrast proponents of reforms which substituted one central administration body to replace the 17 AHSs cited the following advantages:

- substantial saving in corporate and administration costs;
- superior ability to implement and control the reform of processes;
- greater ability to implement centralised speciality planning to prevent duplication of high cost facilities and optimise the location of facilities.

Whilst IPART noted that performance across the AHS was variable, each had its strengths and weaknesses. But many important initiatives are developed and implemented at the Area level. IPART concluded that the AHS model should be retained. On balance, this model was likely to extract most of the available economies of scale, and better able to control and reform the activities of their facilities than a central agency. However, refinements could be incorporated into the current structure to improve delivery and performance.

IPART noted the challenge to provide sufficient central policy direction to avoid excessive duplication and overlap while building upon and promoting initiatives occurring at the AHS level. It considered a critical first step in building on existing structures will be to clarify the role of the AHS.

IPART supported the continued use of AHS boards and believed that boards should utilise the governance model of operation. Under this model, the board sets and oversees the strategic direction and goals of the AHS and ensures the application of good corporate governance. Boards retain their key role of monitoring performance and setting direction.²

2.2 The 2003 IPART Review

The subsequent 2003 IPART report focussed on the same themes as in 1998, and concluded that little had changed. It recommended a national inquiry under the auspices of COAG to address Commonwealth and State funding and division of responsibilities to better coordinate health care delivery.

Again, IPART concluded that the Department of Health and the Area Health Services should rationalise and clarify their roles and responsibilities and strengthen accountabilities in order to better deliver patient care and community

² IPART, [A Review of NSW Health](#). A Report to the NSW Treasurer and Minister for Health. November 1998.

health. IPART stated:

To put it simply: the Department and the Areas need to get on with the jobs for which they are best suited. As IPART noted in its 1998 review of NSW Health, there was a lack of clarity of roles, responsibilities and accountabilities. Little has changed.

IPART observed that the Department devoted too much effort to micro-management, where the Area Health Services should be responsible and accountable for service delivery. Too much effort was focused on day-to-day 'issues' management, with too little to overall policy and long-term strategy formulation and coordination. Operational responsibilities between the Department and the AHSs were often confused. IPART concluded that the Area Health Services often spent too much time 'managing upwards', rather than managing the delivery of services.

Again IPART recommended that the then AHS structure should be retained but the respective roles and responsibilities of the Department and AHSs should be clarified. The Department's role should be focused on strategic planning and policy-setting, whilst AHSs should be made more accountable for meeting the health needs of their areas.

IPART considered the pros and cons of Area amalgamations and the need to review AHS boundaries. It concluded that although there are some potential benefits, it would not be wise to undertake a large-scale review of boundaries while the reforms it had recommended were being implemented.

During its review, IPART saw evidence of considerable variation in the current role and performance of the AHS boards. It concluded that these boards should be retained, but they must be reformed. Boards should be established on the basis that their key roles are to provide corporate governance, strategic leadership and high-level expertise that may not be available within the AHS management. They should not be involved in daily management issues. Nor should they be seen as a primary or significant source of community input. Board members may well be members of the local community, but IPART believed community input to AHSs must be sought through more open, participatory models.³

2.3 The NSW Government Response

The two IPART reports commented on the tussle of health governance between the 17 Area Health Boards on the one hand, and the central control of the Department of Health on the other. The Government's response was firmly in favour of centralising control.

With the passage of the *Health Services Amendment Bill 2004*, the Government reduced the number of Area Health Services from 17 to 8. At the same time, the Act fundamentally changed governance arrangements. Area Health Boards were abolished, with Area Health Services being controlled and managed by a chief

³ IPART, [NSW Health. Focussing on Patient Care](#). 2003

executive, answerable to the Director-General, and in turn the Minister for Health. The Minister noted that this structure:

... provides clear lines of accountability from the chief executive to the director-general, who in turn is accountable to the Minister. This simpler governance structure will make accountability in health administration clearer and better enable NSW Health to progress reforms that involve statewide initiatives or have cross area impacts, such as shared corporate and health support service reform.⁴

In addition, the reforms created Area Health Advisory Councils for each Area Health Service. The Minister continued:

New structures are needed to give health professionals, health consumers and community representatives an enhanced role in the administration of our health system and in setting directions for the delivery of health services. This involvement is critical in keeping area management informed of issues relating to patient care and promoting continuous improvement in patient care and health care quality.⁵

The creation of fewer, larger Area Health Services, and the abolition of their respective boards, was not supported by the Opposition. The then Deputy Leader of the Opposition Barry O'Farrell MP stated:

Liberal and National parties when elected will be firmly focused on patients, on the quality of care offered by our hospitals and clinics, and on supporting those doctors, nurses and allied health professionals and others at work within those facilities. To achieve that we have made clear our intention to reintroduce local hospital boards.

We believe that that initiative would ensure that health services are delivered where they are needed in a way that gives local communities a real say in what services and resources are available at their local hospitals.

Hospital boards and district boards would be structured to ensure that at least half of the representatives were clinicians and others—the very people who provide the services—the other half being members of the community. The health bureaucracy, the general manager and others within our hospital system would be ex officio members. Unlike the current Government, the Coalition believes local communities are best placed to know what services are needed in their regions, and we are prepared to trust those

⁴ NSWPD, Health Services Amendment Bill 2004, 28th October 2004. Second Reading Speech by Hon Morris Iemma MP, Minister for Health

⁵ NSWPD, Health Services Amendment Bill 2004, 28th October 2004. Second Reading Speech by Hon Morris Iemma MP, Minister for Health

local communities with the important task of planning and decision making in relation to our hospital system.⁶

3.0 THE GARLING REPORT

On 29 January 2008 Peter Garling SC was appointed by the Governor of NSW to conduct a Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals. This followed several tragic incidents, including the death of 16 year old Vanessa Anderson at Royal North Shore Hospital. Garling noted: "The coroner lamented that, in Vanessa's case, almost every conceivable error or omission occurred and continued to build on top of one another, leading to Vanessa's death." Garling was charged with investigating systemic and institutional issues in the delivery of acute care and to identify models of patient care in the delivery of acute care services.

The Garling Report was three volumes and some 1200 pages long. This review of the report focuses on those issues relevant to this paper, in particular governance of the hospital system.⁷

3.1 Area Health Services - Clinical vs Corporate Governance

Garling noted that he had received a huge number of submissions highlighting that there had been a shift from clinical governance of corporate matters to corporate governance of clinical matters. He reviewed the Area Health Service structure, and noted the 2005 reforms. Garling concluded:

I accept that the significant changes to the governance structure enacted in 2005, and other factors, have caused a serious loss of morale in senior medical staff, as well as hospital management. That loss of morale is, in my observation, palpable.

... As I have previously noted, the disruption of attempting yet another change to the area health services is simply unacceptable. However the inherent weaknesses of the system as *it is* must be recognised: 2005 created an over-centralised management structure which has alienated clinicians who are the heart of the public hospital system. The remedy is for the area chief executives to devolve power and give managers at the hospital level more autonomy, thereby putting management back in touch with clinicians and responsive to their expertise and vision for the public system.⁸

Garling revisited some of the themes that emerged from the IPART reports. For instance, he noted that the solution to the above identified problems is to devolve decision-making capacity to health services. However, he identified that there is a

⁶ NSWPD, Health Services Amendment Bill, 2nd Reading Debate, 10 November 2004. Mr Barry O'Farrell MP, Deputy Leader of the Opposition

⁷ Garling,P, Special Commission of Inquiry, *Acute Care Services in NSW Public Hospitals. Final Report*. 27 November 2008.

⁸ Garling,P, Special Commission of Inquiry, *Acute Care Services in NSW Public Hospitals. Final Report*. Volume 3, page 1079. 27 November 2008.

lack of clarity about the extent of authority of general managers of hospitals, and that this needs to be clearly defined.

Garling did not support the re-establishment of individual hospital boards. He concluded that individual hospital boards are contrary to the intention of the development of area health services, in which hospitals are intended to operate within a clinical services network across the Area. Individual hospital boards compete for finite resources and do not engender a system of coordinated and efficient clinical care services to the community across a whole area. Nor did Garling support the re-establishment of Area Health Service Boards.

Garling concluded that governance needs to be devolved to a more local level by:

- greater delegation to hospital and unit or ward level;
- greater involvement of clinicians in management decisions; and
- strengthening the structures, including committee structures at hospital level, for communication between management and clinicians.

The NSW Government response to this issue was the establishment of Hospital Clinical Councils. The Minister for Health Hon Carmel Tebbut MP told Parliament:

Hospital clinical councils will provide leadership and advice on the allocation of hospital budgets, quality and safety, recruitment and other key spending decisions, operational management and the achievement of key performance indicators. Hospital clinical councils will also guide local planning and advise on the best way to work with other hospitals and health services. They will oversee the local implementation of Caring Together reforms and work closely with local community groups. Most significantly, hospital clinical councils will be enshrined in the by-laws of the Health Services Act and formal delegations will clearly define their authority and functions.⁹

The Government has stated that these Hospital Clinical Councils will be established across the State by 1 July 2010.

4.0 THE DISTRIBUTION OF HEALTH FUNDING

The NSW Health budget in 2008-09 was \$13.84 billion, comprising some 27% of NSW general government sector expenditure. To help fund public hospital services the Commonwealth provides block grant funding to the states, under Australian Healthcare Agreements. As discussed later, the Commonwealth proposes to radically reform the distribution of health funding, so it is useful to gain an understanding of how health dollars in NSW are managed and distributed now.

4.1 The NSW Resource Distribution Formula

NSW Health uses what is called the resource distribution formula (RDF) as a tool to assist in determining the allocation of funds to each of the Area Health Services. Under the RDF, the weighted population of an Area is calculated according to the numbers within different age and gender categories. The RDF weighting also includes specific need factors such as: the estimated numbers of indigenous

⁹ NSWPD (Proof), Sutherland Hospital Clinical Council. 9 March 2009.

population; homeless population; the number of smaller hospitals; and many other factors including the utilisation rate of private health insurance in the area.

Since its introduction in the late 1980's, the total allocation of health funding has progressively moved towards to an equitable distribution of funds calculated by using the RDF. The difference between the actual amount allocated and the target amount under the RDF has moved considerably so that most areas are now within 2% of their target share of resources.¹⁰

Historically, the Area Health Services have then allocated money to their hospitals according to what they had received the previous year with an allowance for increases in the consumer price index caused by inflation. The historical funding models supported the existing structures irrespective of patient activity and efficiency. Consequently, there was no incentive for hospitals to perform better or to become more efficient.

4.2 Episode Funding

However, there is another model of hospital funding, called a variety of names including: episode funding; activity-funding; case-mix; or diagnosis related group funding. This model fundamentally changes the funding of the health system. Episode funding allocates funds to hospitals according to their level of activity. Each hospital procedure has been or is in the process of being allocated a code according to international classifications. Hospital activity is closely monitored and the idea is that the hospital is funded according to the number and type of procedures performed, rather than a simple block allocation.

As reported later in this paper, the Hospital Reform Commission identified that the shift to casemix based funding for all hospitals will have significant efficiency gains. It observed that, at the moment, it is impossible to validly compare costs for many types of hospital services across the nation. Services are either not classified in the same way across the states, or casemix payments systems are not used. The Commission argued that the introduction of nationally consistent case payment arrangements will facilitate benchmarking, highlight inefficiencies and introduce system wide financial incentives to improve efficiency. It will help governments to understand service utilisation and access to health care, and the availability of comparable data across service settings will assist governments to develop policies and programs that improve the cost-effectiveness of care.

The Commission's preliminary estimate suggested that the shift to activity-based funding for all hospital services is expected to significantly increase efficiency and lead to savings of at least \$0.5 billion up to about \$1.3 billion every year.¹¹

Episode funding was introduced into Victoria in 1993/94 and Garling notes that it has been a very efficient funding model. From 1 July 2008, episode funding was

¹⁰ Garling,P, Special Commission of Inquiry, *Acute Care Services in NSW Public Hospitals. Final Report*. Volume 3, page 901. 27 November 2008.

¹¹ Australian Government, National Health and Hospitals Reform Commission, *A Healthier Future for all Australians. Final Report*, page 150. June 2009.

introduced in NSW as a mandatory funding tool. Area Health Services are now required to use episode funding as a hospital budget setting system and financial performance measurement system. It applies to approximately 86% of NSW public hospital activity and includes admitted acute care, emergency care, intensive care, and designated sub and non-acute patient activity. It does not include primary care or outpatient services. The model currently covers approximately 85% of acute expenditure and 60% of total NSW Health expenditure. The resource distribution formula will continue to guide the allocation of funds to the area health services from NSW Health.¹²

5.0 THE NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION

On 25 February 2008, the Prime Minister and the Minister for Health and Ageing announced the establishment of the National Health and Hospitals Reform Commission. The Commission, chaired by Dr Christine Bennett and nine other Commissioners, actively consulted widely with governments, the health sector and the wider community, and has produced the following reports:

- [Beyond the Blame Game](#), April 2008. This identified key health challenges, developed performance indicators and benchmarks, and developed a set of design and governance principles to underpin the health system.
- [A Healthier Future For All Australians: Interim Report](#), December 2008. The Interim Report proposed reform directions across the whole range of issues facing the health system, and was followed up with more consultation. 280 submissions were received.
- The National Health and Hospitals Reform Commission, [A Healthier Future for All Australians. Final Report](#) June 2009.

This section of the paper reviews the Commission's work, which helps to place into context reforms announced by the Commonwealth Government in March 2010.

5.1 Current Issues Facing the Australian Health System

The Commission noted that the case for health reform is compelling. It noted that while the health system has many strengths, it is a system under growing pressure. Furthermore, it is fragmented with a complex division of funding responsibilities and performance accountabilities between different levels of government.

The report identified actions that can be undertaken by governments to reform the health system under three reform goals:

- Tackling major access and equity issues that affect health outcomes for people now;
- Redesigning our health system so that it is better positioned to respond to emerging challenges; and
- Creating an agile and self-improving health system for long-term sustainability.

The Commission's Final Report included 123 recommendations, which comprised a long-term health reform plan, an overview of which follows:

¹² Garling, P, Special Commission of Inquiry, *Acute Care Services in NSW Public Hospitals. Final Report*. Volume 3. 27 November 2008.

Tackling Major Access and Equity Issues that Affect People Now

- Refreshing our paradigm of universality
- Acting now to improve equity in access and outcomes for people
 - Universal basic dental health services;
 - Timely access to quality care in public hospitals;
 - Crisis mental health services;
 - Closing the gap for Aboriginal and Torres Strait Islander health;
 - Delivering better outcomes for people in remote and rural areas
- Committing to ongoing improvements in access – National Access targets

Redesigning our Health System to Meet Emerging Challenges

- Embedding prevention and early intervention
 - A new Australian Health Promotion and Prevention Agency;
 - Healthy Australia Goals 2020 – everyone taking responsibility for health
 - Shifting the curve of health spending towards prevention;
 - Building prevention and early intervention into our health system;
 - A healthy start to life for all Australian children;
 - encouraging good mental health in our young people.
- Connecting and integrating health and aged care services for people over their lives
 - Primary health care as the cornerstone of our future health system;
 - investing in comprehensive primary health care;
 - A ‘health care home’ for people with chronic and complex needs;
 - Creating ‘hospitals of the future’ and expanding specialty services in the community;
 - Connecting care and support for people with mental illness;
 - Investing in rehabilitation and recovery through sub-acute care;
 - Improving access to palliative care services;
 - increasing choice in aged care.
- Evolving Medicare – beyond a Medicare Benefits Schedule
 - Bringing together state-funded health services and MBS services;
 - Reviewing the scope of services under Medicare;
 - Ensuring affordability through better safety nets;
 - Reshaping the Medicare Benefits Schedule.

Creating an Agile and Self-Improving Health System

- Strengthened consumer engagement and voice
 - Healthy Australia Goals 2020;
 - Building health literacy;
 - Fostering genuine community participation;
 - Empowering consumers to make fully informed decisions;
 - Supporting carers
- A modern, learning and supported health workforce;
 - Valuing and harnessing the expertise of our health workforce;
 - Fostering clinical leadership and governance;
 - Taking a national approach to planning and training a modern health workforce;

- Creating an education and training framework that evolves to meet changing health needs;
- Investing in training infrastructure across health service settings
- Smart use of data, information and communication
 - Person-controlled electronic health record;
 - Giving people ownership of their health information;
 - Enabling an e-health environment;
 - Using information to promote better health outcomes and healthy communities;
 - Promoting a culture of improvement through health performance reporting.
- Well-designed funding and strategic purchasing models
- Knowledge-led continuous improvement, innovation and research.¹³

This paper does not seek to review all of the work of the Hospital Reform Commission. Instead, those elements of it relevant to proposed reforms are discussed. Nevertheless, taken as a package, the Commission's reforms were about transformational change.

5.2 Reforming governance

In Australia, responsibility for health care is divided between two levels of government. The states are directly involved in providing health services, whereas the Commonwealth Government is predominantly involved in funding health services, most of which are privately provided.

The current separation of responsibilities means that no level of government has a detailed understanding of all aspects of the health system. Each level of government formulates policies in relation to its responsibilities, but they do not necessarily take account of the health system as a whole. States also claim that the Commonwealth Government shifts costs on to them through inadequate indexation of grants or by under investing in programs that then cause patients to seek treatment from alternative, state-funded services – for example, general practice patients being treated in hospital emergency departments. These problems are the fundamental source of the 'blame game'.

In its Interim Report, the Commission noted that, as gleaned from its consultations and review of submissions, there was no consensus on a 'single solution' to improve the governance of Australia's health system to ensure better health outcomes. It proposed three options for debate:

Option A – Continued shared responsibility between governments, with clearer accountability and more direct Commonwealth involvement

This option would retain both Commonwealth and state and territory involvement but re-align responsibilities between them, with the Commonwealth:

- Becoming responsible for all funding, policy and regulation for primary health care and community health services, including those currently funded by the states;¹⁴

¹³ The National Health and Hospitals Reform Commission, [A Healthier Future for All Australians. Final Report](#) June 2009.

- Paying to the states and territories a substantial hospital benefit per episode of the efficient costs of inpatient treatment and of emergency department treatment (set at, say, 40 per cent); and
- Paying, using a casemix classification, 100 per cent of the efficient costs of delivery of hospital outpatient treatments.

This option would be established through a National Health Strategy covering all health policies and programs, underpinned in turn by eight bilateral agreements between the Commonwealth and each state and territory.

Option B – Commonwealth solely responsible, with regional providers of some services

The second option was to transfer all responsibility for public funding, policy and regulation to the Commonwealth. The Commonwealth would establish and fund regional health authorities to take responsibility for former state health services such as public hospitals and community health services, as well as continue its national programs of medical and pharmaceutical benefits and aged care subsidies.

The Commonwealth would take on the functions (and presumably many of the staff) of current state health departments including funding, regulation and governance of:

- public hospitals;
- community health services including community mental health services;
- patient transport;
- alcohol and drug services;
- sexual and reproductive health services;
- child and maternal health services;
- school and public dental services;
- health promotion and prevention programs;
- public health protection services; and
- ambulance services

This option would require agreement to transfer substantial funding (almost \$24 billion) from states and territories to the Commonwealth.

The Commission proposed under this option that the Commonwealth would establish regional statutory authorities with responsibility to plan and operate public health services for that population. That is, these authorities would take over most of the formerly state government funded health services within each region.

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The Reform Commission defines Primary Health Care as: Services in the community accessed directly by consumers. It includes primary medical care (general practice), nursing and other services such as community health services, pharmacists, Aboriginal health workers, physiotherapists, podiatrists, dental care and other registered practitioners. It includes community mental health, domiciliary nursing, maternity and early childhood, child and family health, sexual and reproductive health, and other services.

Option C – Commonwealth solely responsible, with competing health plans responsible for providing cover for most services

The third option was to transfer all responsibility for public funding, policy and regulation to the Commonwealth. The Commonwealth would establish a tax-funded community insurance scheme under which people would choose from multiple, competing health plans. These plans would be required to cover a mandatory set of services including, for example, hospital, medical, pharmaceutical and allied health services.

This would see a transfer of responsibility for funding and policy setting of all health services from states and territories to the Commonwealth, with the Commonwealth then delegating purchasing responsibilities to competing health plans. It would be expected that the majority of such plans would be private or non-government, although there would be scope to also have a government (Commonwealth or state) owned and operated health plan(s).

People would be entitled to enrol with their health plan of choice, and every Australian citizen and permanent resident would be required to be enrolled with a health plan. In this regard, social insurance for health care would be similar to compulsory superannuation with fund of choice. Health plans would have no right of refusal – that is, no right to refuse to have an individual as a member of their plan. They would be required to offer cover to rural, regional and remote people on the same basis as to those living in cities.

5.2.1 The Commission's Governance Recommendation

The Commission received much feedback on its three governance options. It ultimately recommended three structural reforms to the governance of the health system, following the lines of Option A. It recommended:

- The Commonwealth Government to be responsible and accountable for the strategic direction, planning and public funding of primary health care. The Commonwealth Government assumes full responsibility for primary health care services. This includes all existing community health services currently funded by state, territory and local governments, covering family and child health services, alcohol and drug treatment services, and community mental health services.
- The Commonwealth Government assume full responsibility for providing universal access to basic dental care (preventive, restorative and dentures).
- The Commonwealth Government assume full responsibility for public funding of aged care services.
- The Commonwealth Government assume full responsibility for the purchasing of all health services for Aboriginal and Torres Strait Islander people.

In regard to the funding of public hospitals and health care services, the Commission recommended that the Commonwealth Government should:

- pay 100 per cent of the efficient cost of public hospital outpatient services using an agreed casemix classification and an agreed, capped activity-based budget;

- pay 40 per cent of the efficient cost of every public patient admission to a hospital, subacute or mental health care facility and every attendance at a public hospital emergency department; and
- pay 100 per cent of the efficient cost of delivering clinical education and training for health professionals across all health service settings, to agreed target levels for each state and territory.

For each of these categories of payment, the Commission stated that the Commonwealth Government must include in the efficient price the relevant proportion (40 per cent or 100 per cent) of the cost of capital. It assumed that the states would mirror these purchasing arrangements, using efficient activity pricing, in funding public hospitals and health services.¹⁵

The Commission observed that the most significant benefit of these proposed arrangements would be that the Commonwealth and state governments would share the financial risk associated with growth in demand for public admitted patient services. This in turn would provide incentives for cooperative action that ensures hospitals are only used when they are the best and most efficient form of care.

The Commission noted that these changes to roles and responsibilities allow for the continued involvement of states, territories and local governments in providing health services. The Commission concluded that as the Commonwealth Government builds capacity and experience in purchasing these public hospital and public health care services, this approach provides the opportunity for its share to be incrementally increased over time to 100 per cent of the efficient cost for these services. In combination with the recommended full funding responsibility by the Commonwealth Government for primary health care and aged care, these changes would mean the Commonwealth Government would have close to total responsibility for government funding of all public health care services across the care continuum – both inside and outside hospitals. This would give the Commonwealth Government a comprehensive understanding of health care delivery across all services and a powerful incentive – as well as the capacity – to reshape funding and influence service delivery so that the balance of care for patients was effective and efficient.

The Commission proposed that the assumption of greater financial responsibility by the Commonwealth Government for the above health services would be met through commensurate reductions in grants to states, territories and local governments and/or through changes to funding agreements between governments.

5.2.2 The Rejection of Interim Report Option B– Regional Networks

The Commission acknowledged that there were some positive features in the option to establish regional networks. However, after further consideration, it did not support the establishment of regional health authorities because:

¹⁵ Australian Government, National Health and Hospitals Reform Commission, *A Healthier Future for all Australians. Final Report*, page 149. June 2009.

- There would be considerable risk in moving quickly to make the Commonwealth Government the single funder of health services, given the Commonwealth Government's lack of experience and capacity in planning and purchasing across the care continuum;
- Experience in other countries has shown that it is difficult to set fair budgets for regions that reflect the health needs of the population, which leads to dissatisfaction and contested decisions;
- The need to adjust for cross-border flows of people adds to complexities;
- There are dangers of 'balkanising' health services, with people's access to care determined by the region they live in;
- In a large country like Australia with a dispersed rural and remote population, it would be difficult for regions to achieve economies of scale; and
- Regional health authorities would be an additional layer, adding to cost and bureaucracy, all requiring governance and management infrastructure.

5.2.3 The Further Consideration of Option 3 – 'Medicare Select'

The Commission concluded that more work is needed to fully develop 'Medicare Select' and test its applicability to the Australian context. It recommended that, over the next two years, the Commonwealth Government commits to exploring the design, benefits, risks and feasibility of implementing health and hospital plans.

The Commission concluded that after 16 months of discussion, debate, consultation, research and deliberation, it was certain that there was a genuine desire for reform of Australia's health system.

6.0 COMMONWEALTH PROPOSALS FOR REFORM OF THE HEALTH SYSTEM

Following the release of the National Health and Hospitals Reform Commission report, the Commonwealth government began a period of consultation around Australia. At the Council of Australian Governments (COAG) meeting on 7 December 2009, health reform was discussed and agreed to be a priority for 2010. The meeting Communiqué stated.

COAG discussed the current pressures on Australia's healthcare system, and emerging pressures including population ageing, health workforce constraints and rising health costs driven by technology and the increasing burden of chronic disease. COAG agreed that long-term health reform was required to deliver better services for patients, more efficient and safer hospitals, more responsive primary healthcare and an increased focus on preventative health.¹⁶

The Commonwealth government subsequently released its health reform plan on 3rd March 2010, entitled: [A National Health and Hospitals Network for Australia's Future](#).

¹⁶ Council of Australian Government, [Communiqué](#), 7 December 2009.

The Commonwealth proposes radical reform to the governance of the Australian health system. This part of the paper reviews the proposed Commonwealth government reforms.

6.1 The Commonwealth as Majority Funder

The Commonwealth stated: "To overcome fragmentation, blame shifting and cost shifting across the health system, the Commonwealth will move to ensure that one level of government has majority funding responsibility for the hospital system."¹⁷

In a fundamental change to hospital funding arrangements, the Commonwealth will increase its funding contribution for public hospital services to:

- 60 per cent of the efficient price of every public hospital service provided to public patients;
- 60 per cent of recurrent expenditure on research and training functions undertaken in public hospitals;
- 60 per cent of capital expenditure, both operating capital and planned new capital investment, to maintain and improve public hospital infrastructure; and
- over time, up to 100 per cent of the efficient price of 'primary health care equivalent' outpatient services provided to public hospital patients.

6.2 Primary Health Care

The Commonwealth paper noted that primary health care in Australia is characterised by complex, fragmented and often uncoordinated delivery systems. Primary health care is currently provided by:

- Private providers such as GPs and allied health professionals;
- State funded community health centres; and
- Outpatient clinics and emergency departments.

In response, the Commonwealth Government will take full responsibility for funding all general practice and primary health care services in Australia. Over time, the Government will also move to fully fund up to 100 per cent of those hospital outpatient services that are better characterised as primary health care.

The Government noted that the importance of this reform is that by taking funding and policy responsibility for all primary health care services, and 60 per cent of public hospital funding, the Commonwealth will have the ability to drive 'allocative efficiency' across the system. This will encourage integrated care and ensure patients are cared for in the most appropriate and efficient setting.

In this way, the Commonwealth recognised that it will have an incentive to ensure the delivery of effective primary health care to keep people out of hospital.

6.3 National Standards

Monitoring and reporting will be undertaken on the performance of the whole health system and that of individual hospitals. The Commonwealth noted that this will

¹⁷ Australian Government, [A National Health and Hospitals Network for Australia's Future](#). March 2010. At p.33.

provide clear and transparent reporting on public and private hospital performance, as well as state performance, and independent reporting on the Commonwealth's primary health care performance.

Other areas in which national standards will be developed include:

- Access to local GPs and other health professionals;
- Financial performance and efficiency; and
- Safety and quality — such as reporting of adverse events and hospital acquired infections.

6.4 Governance

The Government will require the States to introduce Local Hospital Networks to run small groups of hospitals. The Networks are to be established as separate state statutory authorities, and comprise between one and four hospitals. Regional networks may potentially include more small hospitals. The Commonwealth stated that the States will have the flexibility to determine the regional, rural and remote network structure that best meets the needs of their communities and best takes into account the challenges of managing multiple small hospitals.

This will include deciding whether to incorporate smaller regional and remote hospitals within larger Local Hospital Networks, or whether to create further Networks. The Commonwealth stated that Networks would avoid the fragmentation and duplication that would come from individual hospitals operating independently from each other, and also avoid the centralised controls and excess layers of bureaucracy that characterise some systems.

The Commonwealth Government expects that Local Hospital Networks should be established by states within current health department staffing levels. States will be expected to restructure their health departments and regional structures so that people, along with management responsibilities, are devolved to Networks. As a result, the Commonwealth Government will not provide funding for this specific initiative.

Local Hospital Networks will have a professional Governing Council and Chief Executive Officer (CEO), who will be responsible for delivering agreed services and performance standards within an agreed budget. Governing Councils will include local health, management and finance professionals, with an appropriate mix of skills, expertise and backgrounds. Council members will be appointed under state legislation. Each Network's CEO will be appointed by the Council and accountable to the Council.

The devolution of management accountability, combined with paying hospitals directly, places incentives on local managers and clinicians to increase service levels and reduce costs. The Commonwealth Government noted that this will mean that a local hospital should no longer have to seek the approval of a large bureaucracy for matters that relate to the day-to-day delivery of hospital services. Where a Local Hospital Network operates more efficiently, they will be able to locally retain and re-invest the financial benefits. In addition, future Commonwealth Government payments will be designed to reward Networks for good performance — and provide Networks with local flexibility and choice in how to invest the

proceeds of good performance.

6.5 The role of States and Territories

States will continue to be responsible for meeting the remaining costs of public hospital services, including meeting any costs over and above the efficient price, as well as the remainder of teaching, research and capital costs. The Commonwealth stated that this creates a strong incentive for the States to be as efficient as possible in playing their ongoing role in our public hospital system.

State governments will also continue to own public hospital assets. They will work with Local Hospital Networks to determine the range and number of public hospital services to be provided within their jurisdiction and to be responsible for all aspects of industrial relations policy and employment of the public hospital workforce. States will also continue to have responsibility for the delivery of essential health related services such as ambulance and patient assisted travel schemes.

6.6 The role of State Health Departments

State health departments will have a different role in this system. State health departments will specialise in system-wide service planning and performance management issues, and work with Networks to negotiate service contracts, meet unanticipated challenges, transfer good practice and identify and remediate poor practice. Some functions, such as procurement, may be more effectively administered at a state level. Networks will be the employers of hospital staff, but with conditions of employment managed by states.

In circumstances in which independent and transparent reporting concludes that Network performance is good, the Commonwealth noted that Governing Councils and CEOs could expect relatively 'light touch' management from states in an earned autonomy system. Conversely, where Network performance is not meeting the performance standards outlined in the service contract, state health departments will take a more visible and intrusive role. As a last resort, the Council may decide to remove the CEO, or the state Minister may choose to remove the Chair of the Council, or both. As part of its national leadership role, the Commonwealth will be alerted to poorly performing hospitals, and will require states to step in and fix these problems.

6.7 Funding - Paying Local Hospital Networks Directly

Presently, the Commonwealth supports the delivery of free public hospital services through block grant funding paid to the states. Each State then determines funding for individual hospitals. There is considerable variation in mechanisms for payment to individual hospitals around the country.

The Commonwealth Government stated that it will increase the efficiency and transparency of public hospital funding by directly funding Local Hospital Networks for each service provided to a patient, through activity based funding. Local Hospital Networks will have the assurance of directly receiving payments linked to the number and type of services that they provide.

Under the new arrangements, the Commonwealth will fund 60 per cent of the efficient price of every public hospital service Local Hospital Networks provide.

The Commonwealth will move to a nationally consistent patient level costing and pricing regime for public hospitals over time. This will be undertaken through the establishment of an activity based funding unit price, a series of loadings that adjust the price for the most important patient and hospital factors, and a series of cost weights that reflect the cost differences between different diagnoses and procedures. To do this, the Government will accelerate the activity based funding work program agreed with states at COAG in November 2008.

To ensure that the nationally efficient price is determined on a fair and equitable basis, the Commonwealth will establish what it referred to as an independent umpire to set the nationally efficient price and advise the Government on appropriate timelines and path for transition for all hospital services. In setting the nationally efficient price, the umpire will be required to strike an appropriate balance between reasonable access, clinical safety, efficiency and fiscal considerations. Price loadings will be established to recognise, for example, the particular circumstances and health care needs of people living in rural Australia and Indigenous Australians.

The Commonwealth will assume greater financial responsibility by progressively moving from payment for public hospital services on the basis of recurrent expenditure to payment on the basis of a national efficient price for each hospital service.

6.8 Implementation

The Commonwealth Government will continue working closely with state governments through the COAG process to ensure the reforms in this plan are implemented as quickly as possible. These essential reforms are required as building blocks for future reforms, and to ensure that additional investment in the system is used efficiently and effectively. Should the states not agree to the Plan, the Commonwealth also reserves its right to seek a mandate from the Australian people to implement the Plan. Furthermore, consistent with the Government's previous commitments, the Commonwealth also reserves the right to then proceed to a full funding takeover of the system in the future.

It will finance these changes by dedicating around one-third of total GST revenue — all of which is currently provided to the states — directly to health and hospital services across the country. The proportion of GST dedicated to health care will gradually grow over the upcoming forward estimates, and then be fixed over time from 2013–14. This means this reform is expected to be revenue neutral to the states and the Commonwealth over the upcoming forward estimates, and that all states will benefit from this reform over the longer term.

The total GST pool (including GST payments dedicated to health care) will continue to be distributed across the states in accordance with relativities recommended by the Commonwealth Grants Commission.

6.9 The NSW Government Response

In response to the Commonwealth proposals the NSW Premier Hon Kristina Keneally MP told Parliament:

... The Prime Minister's announcement represents an opportunity for fundamental change on how we deliver health services. And this is something that the New South Wales Government has long called for. We know that to do nothing is not an option.¹⁸

... This is a once-in-a-generation opportunity and the Government is seizing it with both hands because the communities of New South Wales recognise that it is an opportunity to work hand-in-hand with the Commonwealth to deliver better health outcomes for our families.¹⁹

... We welcome the potential, but we want to ensure that New South Wales communities will be protected in the detail of the plan.²⁰

The State Government announced a three-step process it intends to follow before responding to the Commonwealth's proposal. This included:

- A [discussion paper](#)²¹ on the possible implications of the national health plan on NSW funding, service delivery, and workforce.
- A half-day working seminar of up to 50 medical professionals and care providers to canvass key issues raised in the proposal.
- A public submission process that would be conducted through a new [online forum](#).²²

6.10 Comment Governance

It could be argued that the governance and structure of a health system is a major determinant of its success, or otherwise. The National Health and Hospitals Reform Commission rejected the argument for regional health authorities. Instead it recommended that the Commonwealth take over primary health care, and pay 40% of the cost of public hospital admissions in partnership with the states and territories. Clearly, the Commonwealth government has rejected this recommendation.

The proposed introduction of Local Hospital Networks and governing councils is a major departure from current NSW practice. In 2005 NSW abolished Area Health Boards, the structure most resembling governing councils. Themes from the earlier IPART reports are relevant here. In this case, IPART reported at length on the need to clearly articulate the role of the Area Health Services and that of NSW Health. Similarly, it will be vital that the roles of the Local Hospital Networks and NSW Health are clearly defined.

¹⁸ NSWPD, 9 March 2010.

¹⁹ NSWPD, 11 March 2010.

²⁰ NSWPD, 16 March 2010.

²¹ NSW Government, [National Health Reform. Discussion Paper on the Federal Government's Proposal for a National Health and Hospitals Network for Australia's Future](#). March 2010.

²² See: <https://health.reform.discussions.nsw.gov.au/>

Accountability

The Commonwealth proposes to establish Local Hospital Networks, each with a governing council. These councils will be responsible for delivering agreed services and performance standards within an agreed budget. Where performance standards are not being met, the Commonwealth stated that it will require states to step in and fix these problems.

In this case, the Commonwealth proposes to implement a new health governance structure, and majority fund the public health system. But where a part of the health system fails, it expects the minority partner to accept responsibility for it and 'fix it'.

Again it is noteworthy to learn from the earlier IPART reports. To recap, IPART observed that the media and community seemed to be moving NSW Health to adopting a role of being accountable for the outcome of every patient in the public system. This system-wide accountability has seen NSW Health retract some of the management autonomy of the AHSs.

With a health system the size it is in NSW, it is almost inevitable that tragic avoidable health incidents will occur in the future. It will be interesting to see where the media and the community lay blame in the future.

Funding

The Commonwealth Government proposal to fund Local Hospital Networks directly according to activity based funding is a significant reform. Unless carried out with care, smaller hospitals in rural and remote regions could be disadvantaged.

The 1998 IPART report covered some of these issues, and noted that rural residents tend to have greater health needs compared to their urban counterparts. Morbidity rates and death rates from all causes are higher in rural and remote areas compared to urban areas. Further, Aboriginal people generally suffer from substantially poorer health, compared to other Australians, because of poor socioeconomic and health status. Overall, the per capita health service needs of Aboriginal populations are significantly greater.

IPART also noted that rural regions have fewer community based health services, private nursing home beds, and private health care providers compared to urban regions and this places greater reliance on public hospital facilities and services. Further, rural regions have fewer General Practitioners which reduces competition in the delivery of medical services and this lowers the opportunity for local residents to have access to bulk billing. Consequently, there is a greater onus on hospitals to provide medical services in rural regions.

IPART concluded that standardized hospital inpatient costs for the rural AHSs are, on average, about 11% higher than metropolitan AHSs.

In his report Garling noted some important questions in regard to episode funding, including who will decide how many types of a particular procedure will be performed each year? He asked whether this will be doctors, having regard to

patient need, or NSW Health working within the budget it is given, or will it be a matter for government through the funding allocation mechanism? Garling noted that it is unclear whether episode funding will give the control to the Area Health Services, NSW Health, or the Treasury to determine how many of a particular type of treatment will occur and in what level of hospital. He concluded that a clear answer to this question is necessary before he would be prepared to express with confidence any opinion about the appropriateness of moving the entire funding of the health portfolio to be based on episode funding.

NSW Health told the Garling Inquiry that the introduction of episode funding would pose considerable problems unless it is accompanied by an agreement with NSW Treasury about the level of activity it will fund in the health system.

The Number of Administrative Structures

How many Local Hospital Networks should be established across NSW is a crucial question. Currently, NSW is divided into 8 Area Health Service regions. Prior to 2005, there were 17. Appendices One and Two outline the local government areas and hospitals in the Area Health Services, both currently and prior to the 2005 reforms. The Prime Minister has spoken of some 150 Local Hospital Networks across Australia, meaning that on a population basis around 50 would be in NSW. Senior members of the health profession are not sure how Networks on this small scale would work in practice, arguing that they would be too small to provide comprehensive services. It was also stated that they would create substantial administrative costs that were duplicated dozens of times across the State.²³

The Garling report touched on this issue, both in terms of governance and also in terms of hospital capability. Whilst Garling was referring to individual hospitals, the same sentiment could be applied to the proposed Local Hospital Networks. For instance, Garling recommended (No. 117) a complete state-wide review by NSW Health which involves:

- The identification of a set of criteria, which relate to at least, patient safety, necessary workforce skills, the volume and quality of services regarded as an appropriate critical mass for the services provided across NSW in public hospitals;
- A determination of whether each hospital, having regard to its location, the available workforce determined on a long term basis, the size of the population which it services, the alternative locations within an appropriate distance (measured by time or distance) and the age and state of repair of the facilities and equipment, is (or can become) a location for the delivery of safe patient care;
- A clear delineation of the role of each hospital – what it can and can't do;
- Clear communication of the role of a local hospital to its community, and community understanding of the limitations of the local hospital;
- Re-allocation of specialist medical services to hospitals in NSW best placed to deliver those services; and

²³

“Hospital networks too small for services” in *The Sydney Morning Herald*, 16 March 2010.

- The consideration of the availability of an efficient transport and retrieval system state-wide to transport patients to the hospital best placed to provide the medical service required, and return the patient to their original locations.

The NSW Government subsequently supported this recommendation, and noted:

Planning for a statewide review will begin immediately and include community and workforce consultation. Supported by existing health service plans the review will analyse population size and distribution, ageing, level of disease, changing models of care and lifestyle to agree on services that are needed and can be provided safely. Highly Specialised Services will be considered on a statewide level. The issue of patient safety will be paramount and considered in light of both the availability of an appropriately qualified workforce and the provision of appropriate facilities.²⁴

7.0 CONCLUSION

In its Interim Report, the National Health and Hospitals Reform Commission noted that there was no consensus on a 'single solution' to how to improve the governance of Australia's health system. With no readily identified consensus, the Commission's Final Report recommended some transformational, but incremental changes. In response, the Federal Government proposals are certainly transformational. In particular, the introduction of Local Hospital Networks and their respective governing councils can be seen as a direct challenge to the centralised administration of health in NSW.

Whilst COAG has agreed that health reform is a priority for 2010, it is likely that the lack of consensus of a single solution in the community as identified by the Reform Commission will be also reflected at COAG. Whilst the NSW Premier has indicated that NSW will enter into serious negotiations with the Commonwealth, other States have been less than forthcoming. For instance, the Western Australia Premier stated:

...these are our hospitals, for which the government of the day and the Parliament have responsibility. I do not believe that they should simply be handed over to the commonwealth government...

Our system is not perfect. It makes mistakes. It has gaps. We recognise that. But to simply turn our health system on its head and hope it will be okay is not good enough. We are prepared to be convinced, but it will take strong argument and strong evidence that health care will be improved.²⁵

Indeed, consensus in the wider medical community is likely to be just as elusive. In response to the Commonwealth proposals the President of the Australian Medical Association Dr Pesce stated:

²⁴ NSW Government, [Caring Together. The Health Action Plan for NSW](#). 2009

²⁵ WAPD, 9th March 2010. Reply by the Premier Barnett: [Federal Government Hospital Reform Proposal](#).

... the public hospitals policy unveiled by the Prime Minister is major reform that must be taken seriously and given due consideration by the States and the health sector because we need a system that will give better access to quality health services for the Australian population into the future.

... the policy is a credible response to the problems and deficiencies in the public hospital system and is evidence that there has been considerable consultation with patients and with doctors.²⁶

[and in a speech]...Whether you agree with it or not – wholly or partially – it represents a quantum shift in thinking. And that is just what our health system needs right now – BIG REFORM.²⁷

The Doctors Reform Society had concerns about the perceived lower priority of primary health care, and stated:

The Prime Minister's proposed shake up of public hospital funding has the capacity to reduce waiting lists to see specialists, to have surgery, and to get seen in Emergency department when needed.

It appears however, that Primary Care, ie care in the community from GPs, nurses, psychologists, and other allied health professionals, is a very low priority with minimal changes suggested. ... Whilst the idea of funding nationally and organising the provision of services locally is the basis for the reformed hospital funding model, such a model has not been suggested for Primary Care, despite the obvious appalling inequities in access to such care, and the inefficiencies and lack of co-ordination in Primary Care. Canberra based programs and policy will not address these issues. Neither Superclinics nor some extra money to Divisions to carry out some preventive care will address this problem.²⁸

Similarly, David Crosbie, CEO of the Mental Health Council of Australia, noted that hospital reform is only one part of the health system reform that Australia needs. He stated:

We have long argued for greater accountability and transparency in mental health services, particularly empowering health consumers to have access to better information and choice. This is undoubtedly a step forward, an important step that is the basis of ongoing reform. At the same time it is important to remember that the National Health and Hospitals Reform Commission (NHHRC) also identified the need for significant reform to dental services, primary healthcare, preventative health and mental health services.

²⁶ Australian Medical Association, [Media Release](#) "Major health reform must be given a chance to deliver – AMA." 3rd March 2010.

²⁷ Australian Medical Association, "[Putting Health Reform above Party Politics - AMA President addresses AMA Parliamentary Dinner, Canberra](#)" 10 March 2010.

²⁸ Doctors Reform Society, [Media Release](#) "Hospital reform promising, primary care almost forgotten." 3rd March 2010.

One of the important points to remember is that hospitals are not islands in the health service system. In the area of mental health, we know that over 40% of people currently occupying acute mental health beds in hospitals would not be there if community based sub acute care and other options were available.

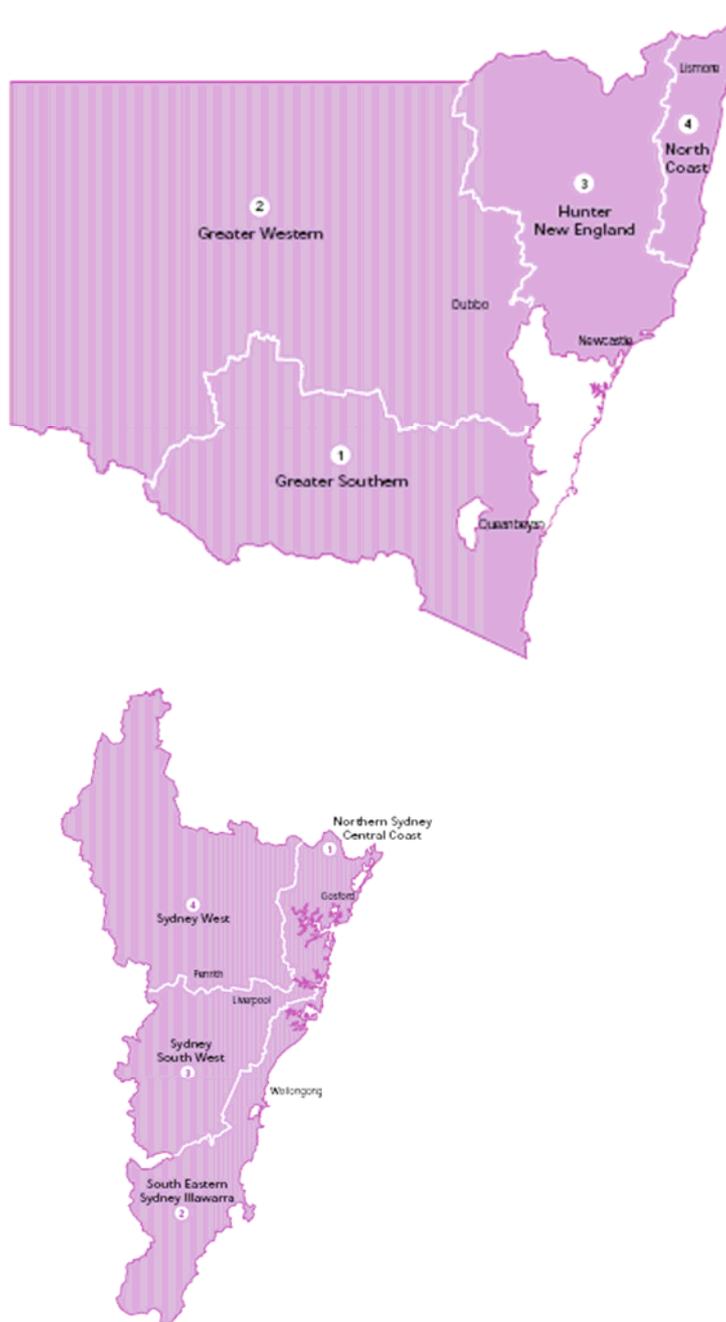
Fixing hospitals is very important. Fixing the systems that feed into hospitals and leave people marooned with no other options is also critical.²⁹

²⁹ Mental Health Council of Australia, [Media Release](#) "Health Reform – Next Step Must be Mental Health." 3 March 2010.

Appendix One

Current Area Health Services in NSW

Figure One: Metropolitan and Regional Area Health Services 2009



Source: NSW Department of Health, [Annual Report](#) 2008-09

Northern Sydney Central Central Coast AHS**Local government areas**

Gosford, Hornsby, Hunters Hill, Ku-ring-gai, Lane Cove, Manly, Mosman, North Sydney, Pittwater, Ryde, Warringah, Willoughby, Wyong

Public hospitals

Gosford Hospital
Hornsby Ku-ring-gai Hospital
Long Jetty Healthcare Centre
Macquarie Hospital
Manly Hospital
Mona Vale Hospital
Royal North Shore Hospital
Ryde Hospital
Wyong Hospital
Woy Woy Hospital

Public nursing homes

Hope Healthcare - Graythwaite Nursing Home,
Greenwich Hospital, Neringah Hospital,
Royal Rehabilitation Centre Sydney

Community health centres

Kincumber Community Health Centre
Lake Haven Community Health Centre
Long Jetty Community Health Centre
Erina Community Health Centre
Mangrove Mountain Community Health Centre
Toukley Community Health Centre
Woy Woy Community Health Centre
Wyong Community Health Centre
Wyong Central Community Health Centre

Child and family health

Berowra Community Health Centre
Brooklyn Community Health Centre
Galston Community Health Centre
Hillview Community Health Centre
Hornsby Child & Family Health Centre
Pennant Hills Community Health Centre
Richard Geeves Centre – Dementia Day Centre
Wiseman's Ferry Community Health Centre
Brookvale Early Intervention Centre
Dalwood Assessment Centre
Frenchs Forest Community Health Centre
Mona Vale Community Health Centre
Queenscliff Community Health Centre
Ryde Hospital and Community Health Service
Macquarie Hospital
Child and Family Health

North Shore/Ryde Community Health Centre
Ryde Child and Family Health Service

South Eastern Sydney Illawarra AHS

Local government areas

Botany Bay, Hurstville, Kiama, Kogarah, Lord Howe Island, Randwick, Rockdale, Shellharbour, Shoalhaven, Sutherland, Sydney (part), Waverley, Wollongong, Woollahra

Public hospitals

Bulli Hospital
Coledale Hospital
David Berry Hospital
Kiama Hospital
Milton Ulladulla Hospital
Port Kembla Hospital
Prince of Wales Hospital and Community Health Service
Royal Hospital for Women
Shellharbour Hospital
Shoalhaven
St George Hospital and Community Health Service
Sydney Children's Hospital
Sydney Hospital and Sydney Eye Hospital
The Sutherland Hospital and Community Health Service
Wollongong Hospital
Third Schedule facilities
Calvary Healthcare
Gower Wilson Memorial Hospital
(Lord Howe Island)
St Vincent's Hospital
War Memorial Hospital (Waverley)

Sydney South West AHS

Local government Areas

Ashfield, Bankstown, Burwood, Camden, Campbelltown, Canada Bay, Canterbury, Fairfield, Leichhardt, Liverpool, Marrickville, Strathfield, City of Sydney (part), Wingecarribee, Wollondilly

Public Hospitals

Balmain Hospital
Bankstown-Lidcombe Hospital
Bowral and District Hospital
Camden Hospital
Campbelltown Hospital
Canterbury Hospital
Concord Centre for Mental Health
Concord Repatriation General Hospital
Fairfield Hospital
Liverpool Hospital

Royal Prince Alfred Hospital
Sydney Dental Hospital
Thomas Walker Hospital
Third schedule facilities
Braeside Hospital
Carrington Centennial Care
Karitane
Queen Victoria Memorial Home
Tresillian Family Care Centres

Other services

Department of Forensic Medicine
Sydney South West Pathology Services

Sydney West AHS**Local government areas**

Auburn, Baulkham Hills, Blacktown, Blue Mountains, Hawkesbury, Holroyd, Lithgow, Parramatta, Penrith

Public hospitals

Auburn Hospital
Blacktown Hospital
Blue Mountains District ANZAC Memorial Hospital
Cumberland Hospital
Lithgow Hospital
Lottie Stewart Hospital
Mt Druitt Hospital
Nepean Hospital
Portland Hospital
Springwood Hospital
St Joseph's Hospital
Westmead Hospital

Community health centres

Auburn, Blacktown, Cranebrook, Doonside, Dundas, Hawkesbury, Katoomba, Kingswood, Lawson, Lithgow, Merrylands, Mt Druitt, Parramatta, Penrith, Portland, Richmond, Springwood, St Clair, St Marys, The Hills.

Other services

Anxiety Clinic
Blue Mountains Access Team
Child and Adolescent Mental Health Team
Consultation Liaison - Emergency Department, Nepean Hospital Early Psychosis
Intervention Borec House
Hawkesbury Mental Health Team
Hornseywood House
Katoomba Mental Health
Lithgow Community Mental Health Team
Mental Health Information Development Unit
PECC Unit - Emergency Department, Nepean Hospital Penrith Access -

Community Assessment and Liaison Centre
Penrith Mental Health
Pialla Unit
Psychological Medicine
Springwood Mental Health
St Marys Mental Health
Westworks

Greater Southern AHS

Local government areas

Albury, Bega Valley, Berrigan, Bland, Bombala, Boorowa, Carrathool, Conargo, Coolamon, Cooma Monaro, Cootamundra, Corowa, Deniliquin, Eurobodalla, Goulburn, Mulwaree, Greater Hume, Griffith, Gundagai, Harden, Hay, Jerilderie, Junee, Leeton, Lockhart, Murray, Murrumbidgee, Narrandera, Palerang, Queanbeyan, Snowy River, Temora, Tumbarumba, Tumut, Upper Lachlan, Urana, Yass Valley, Wagga Wagga, Wakool

Public hospitals

Barham Koondrook Soldiers' Memorial Hospital
Batemans Bay District Hospital
Batlow Multi-purpose Service
Bega District Hospital
Berrigan Multi-purpose Service
Bombala Multi-purpose Service
Boorowa Hospital
Bourke Street Health Service
Braidwood Multi-purpose Service
Coolamon Multi-purpose Service
Cooma Hospital
Cootamundra Hospital
Corowa Hospital
Crookwell Hospital
Culcairn Multi-purpose Service
Delegate Multi-purpose Service
Deniliquin District Hospital
Finley Hospital
Goulburn Hospital
Griffith Base Hospital
Gundagai District Hospital
Hay Hospital and Health Service
Henty Multi-purpose Service
Hillston District Hospital
Holbrook District Hospital
Jerilderie Multi-purpose Service
Junee Multi-purpose Service
Kenmore Hospital
Leeton District Hospital
Lockhart Hospital
Moruya District Hospital
Murrumburrah-Harden Hospital

Narrandera District Hospital
Pambula District Hospital
Queanbeyan District Health Service
Temora & District Hospital
Tocumwal Hospital
Tumbarumba Multi-purpose Service
Tumut District Hospital
Urana Multi-purpose Service
Wagga Wagga Health Service
West Wyalong Hospital
Yass District Hospital
Young District Hospital

Third Schedule facilities

Mercy Health Service Albury
Mercy Care Centre Young

Greater Western AHS**Local government areas**

Balranald, Bathurst Regional, Blayney, Bogan, Bourke, Brewarrina, Broken Hill, Cabonne, Central Darling, Cobar, Coonamble, Cowra, Dubbo, Forbes, Gilgandra, Lachlan, Mid-Western, Narromine, Oberon, Orange, Parkes, Walgett, Warren, Warrumbungle, Weddin, Wellington, Wentworth, Un-incorporated Far West

Public hospitals

Balranald District Hospital
Baradine Multi-purpose Service
Bathurst Base Hospital
Blayney Multi-purpose Service
Bloomfield Hospital
Bourke District Hospital
Brewarrina Multi-purpose Service
Broken Hill Base Hospital
Canowindra Soldiers' Memorial Hospital
Condobolin District Hospital
Cowra District Hospital
Cudal War Memorial Hospital
Cobar District Hospital
Collarenebri Multi-purpose Service
Coolah Multi-purpose Service
Coonabarabran District Hospital
Coonamble District Hospital
Dubbo Base Hospital
Dunedoo War Memorial Hospital
Eugowra Memorial Hospital
Forbes District Hospital
Gilgandra Multi-purpose Service
Goodooga Community Health Service
Grenfell Multi-purpose Service
Gulargambone Multi-purpose Service

Gulgong District Hospital
Ivanhoe District Hospital
Lake Cargelligo Multi-purpose Service
Lightning Ridge Multi-purpose Service
Menindee Health Service
Molong District Hospital
Mudgee District Hospital
Narromine District Hospital
Nyngan District Hospital
Oberon Multi-purpose Service
Orange Base Hospital
Parkes District Hospital
Peak Hill Hospital
Rylstone Multi-purpose Service
Tibooburra District Hospital
Tottenham Hospital
Tullamore Hospital
Trangie Multi-purpose Service
Trundle Multi-purpose Service
Warren Multi-purpose Service
Wellington Hospital, Bindawalla
Walgett District Hospital
Wentworth District Hospital
Wilcannia Multi-purpose Service

Hunter New England AHS

Local government areas

Armidale Dumaresq, Cessnock, Dungog, Glen Innes Severn, Gloucester, Great Lakes, Greater Taree, Gunnedah, Guyra, Gwydir, Inverell, Lake Macquarie, Liverpool Plains, Maitland, Moree Plains, Muswellbrook, Narrabri, Newcastle, Port Stephens, Singleton, Tamworth Regional, Tenterfield, Upper Hunter, Uralla, Walcha

Public hospitals

Armidale Hospital
Belmont Hospital
Cessnock Hospital
Glen Innes Hospital
Gloucester Hospital
Gunnedah Hospital
Inverell Hospital
James Fletcher Hospital
John Hunter Hospital
John Hunter Children's Hospital
Kurri Kurri Hospital
Manilla Hospital
Moree Hospital
Morisset Hospital
Muswellbrook Hospital
Narrabri Hospital

Quirindi Hospital
Royal Newcastle Centre
Scone Hospital (Scott Memorial)
Singleton Hospital
Tamworth Hospital
Taree (Manning) Hospital
The Maitland Hospital

Third Schedule Facilities

Calvary Mater Newcastle

North Coast AHS**Local government areas**

Ballina, Bellinger, Byron, Clarence Valley, Coffs Harbour, Kempsey, Kyogle, Lismore, Nambucca, Port Macquarie-Hastings, Richmond Valley, Tweed

Public hospitals

Ballina District Hospital
Bellinger River District Hospital
Bonalbo Health Service
Byron District Hospital
The Campbell Hospital, Coraki
Casino & District Memorial Hospital
Coffs Harbour Health Campus
Dorrigo Multi-purpose Service
Grafton Base Hospital
Kempsey District Hospital
Kyogle Memorial Multi-purpose Service
Lismore Base Hospital
Macksville Health Campus
Maclean District Hospital
Mullumbimby & District War Memorial Hospital
Murwillumbah District Hospital
Nimbin Multi-purpose Service
Port Macquarie Base Hospital
The Tweed Hospital
Urbenville Multi-purpose Service
Wauchope District Memorial Hospital

Appendix Two

Area Health Services Prior to 2005 Reforms

Sourced from NSW Health Annual Report, 2003-04.

Figure 2: Metropolitan and Regional Area Health Services pre-2005 Reforms



Source: NSW Department of Health, [Annual Report](#) 2003-04.

Central Coast Area Health Service**Local government areas**

Gosford, Wyong

Public hospitals

Gosford Hospital

Long Jetty Health Care Centre

Woy Woy Hospital

Wyong Hospital

Central Sydney AHS**Local government areas**

Ashfield, Burwood, Canada Bay, Leichhardt, Marrickville, Strathfield and Sydney (part)

Public hospitals

Balmain Hospital

Canterbury Hospital

Concord Repatriation

General Hospital

Dame Eadith Walker Hospital

Royal Prince Alfred Hospital

Rozelle Hospital

Thomas Walker Hospital (Rivendell)

Sydney Dental Hospital

Other services

RPAH Institute of Rheumatology & Orthopaedics

Department of Forensic Medicine

Division of Population Health

Tresillian Family Care Centre

Hunter AHS**Local government areas**

Cessnock, Dungog, Gloucester, Great Lakes, Greater Taree, Lake Macquarie, Maitland, Muswellbrook, Newcastle, Port Stephens, Singleton, Upper Hunter

Public hospitals/polyclinics

Belmont District Hospital

Bulahdelah District Hospital*

Cessnock District Hospital

Denman Hospital

Dungog and District Hospital

Gloucester Soldiers' Memorial Hospital*

James Fletcher Hospital

John Hunter Hospital

John Hunter Children's Hospital

Kurri Kurri District Hospital

Maitland Hospital

Manning Base Hospital*

Merriwa District Hospital
Morisset Hospital
Muswellbrook District Hospital
Nelson Bay Polyclinic
Newcastle Mater Misericordiae Hospital
Rankin Park Day Hospital and Inpatient Unit
Royal Newcastle Hospital
Scott Memorial Hospital, Scone
Singleton District Hospital
Toronto Polyclinic
Wilson Memorial Hospital, Murrurundi
Wingham and District War Memorial Hospital*

Public aged care facilities

Muswellbrook Aged Care Facility
Wallsend Aged Care Facility

Illawarra AHS**Local government areas**

Kiama, Shellharbour, Shoalhaven, Wollongong

Public hospitals

Bulli District Hospital
Coledale District Hospital
David Berry Hospital
Kiama Hospital
Milton-Ulladulla Hospital
Port Kembla Hospital
Shellharbour Hospital
Shoalhaven District
Memorial Hospital
Wollongong Hospital

Northern Sydney AHS**Local government areas**

Hornsby, Hunters Hill, Ku-ring-gai, Lane Cove, Manly, Mosman, North Sydney, Pittwater, Ryde, Warringah, Willoughby

Public hospitals

Greenwich Hospital (part of Hope Healthcare)
Hornsby Ku-ring-gai Hospital
Macquarie Hospital
Manly Hospital
Mona Vale Hospital
Neringah Hospital (part of Hope Healthcare)
Royal North Shore Hospital
Royal Rehabilitation Hospital,
Coorabel/Moorong
Ryde Hospital

Public nursing homes

Graythwaite Nursing Home (part of Hope Healthcare)
St Catherine's Villa

Other services

Kolling Institute
Northern Sydney Home
Nursing Service
Sydney Dialysis Centre

South Eastern Sydney AHS**Local government areas**

Botany Bay, Hurstville, Kogarah, Randwick, Rockdale, Sutherland, Sydney (part),
Waverley, Woollahra, Lord Howe Island

Public hospitals

Calvary Health Care Sydney
Prince of Wales Hospital
Royal Hospital for Women
St George Hospital
St Vincent's Hospital Sydney Ltd
Sacred Heart Hospice
Sutherland Hospital
Sydney Children's Hospital and Community Health Services, Randwick
Sydney Hospital
Sydney Eye Hospital (including the Langton Centre, Kirketon Road Centres and
Sydney Sexual Health Centre)
War Memorial Hospital, Waverley

Public nursing homes

Garrawarra Centre, Waverley
South Eastern Health also has administrative responsibility for the Gower Wilson
Memorial Hospital on Lord Howe Island and Area-wide services and programs.

Other services

Eastern Sydney Scarba Service and Early Intervention Program

South Western Sydney AHS**Local government areas**

Bankstown, Camden, Campbelltown, Fairfield, Liverpool, Wingecarribee,
Wollondilly

Public hospitals

Bankstown-Lidcombe Hospital
Bowral District Hospital
Braeside (part of Hope Healthcare)
Camden Hospital
Campbelltown Hospital
Carrington Centennial
Hospital Karitane

Fairfield Hospital
Liverpool Hospital

Public nursing homes

Queen Victoria Memorial Home, Thirlmere

Wentworth AHS

Local government areas

Blue Mountains, Hawkesbury, Lithgow*, Penrith

Public hospitals

Blue Mountains District ANZAC Memorial Hospital
Nepean Hospital
Springwood Hospital
Tresillian Wentworth

Public nursing homes

Governor Phillip Nursing Home
Bodington Red Cross Hospital,
Wentworth Falls (run by Catholic Health Care)

Western Sydney AHS

Local government areas

Auburn, Baulkham Hills, Blacktown, Holroyd, Parramatta

Public hospitals

Auburn Hospital
Blacktown Hospital
Cumberland Hospital
Lottie Stewart Hospital
Mt. Druitt Hospital
St Joseph's Hospital, Auburn
Westmead Hospital

Far West AHS

Local government areas

Balranald, Bourke, Brewarrina, Broken Hill, Central Darling, Walgett, Wentworth,
Unincorporated Area

Public hospitals

Balranald District Hospital
Bourke District Hospital
Brewarrina Multi-Purpose Service
Broken Hill Base Hospital
Collarenebri Multi-Purpose Service
Goodooga Community Health Service
Lightning Ridge Multi-Purpose Service
Menindee Health Service
Ivanhoe District Hospital

Tibooburra District Hospital
Walgett District Hospital
Wentworth District Hospital
Wilcannia Multi-Purpose Service

Other public health facilities

Dareton Primary Care and Community Health Centre
Wanaaring Community Health Service
White Cliffs Nursing Service

Greater Murray AHS

Local government areas

Albury, Berrigan, Bland, Carrathool, Conargo, Coolamon, Cootamundra, Corowa, Deniliquin, Greater Hume, Griffith, Gundagai, Hay, Jerilderie, Junee, Leeton, Lockhart, Murray, Murrumbidgee, Narrandera, Temora, Tumbarumba, Tumut, Urana, Wagga Wagga, Wakool

Public hospitals

Albury Base Hospital
Barham Koondrook Soldiers'
Memorial Hospital
Batlow District Hospital
Berrigan War Memorial Hospital
Coolamon-Ganmain Health Service
Cootamundra Hospital
Corowa District Hospital
Culcairn Health Service
Deniliquin Hospital
Finley Hospital
Griffith Base Hospital
Gundagai District Hospital
Hay Health Service
Henty District Hospital
Hillston District Hospital
Holbrook District Hospital
Jerilderie District Hospital
Junee Hospital
Leeton District Hospital
Lockhart and District Hospital
Mercy Care Centre, Albury
Narrandera District Hospital
Temora and District Hospital
Tocumwal Hospital
Tumbarumba Health Service
Tumut Hospital
Urana Health Service
Wagga Wagga Base Hospital
West Wyalong Hospital

Macquarie AHS**Local government areas**

Bogan, Cobar, Coolah, Coonabarabran, Coonamble, Dubbo, Gilgandra, Mid-Western Regional (part) Narromine, Warren, Wellington

Public hospitals

Baradine Multi-Purpose Service
Cobar District Hospital
Coolah Multi-Purpose Service
Coonabarabran District Hospital
Coonamble District Hospital
Dubbo Base Hospital
Dunedoo War Memorial Hospital
Gilgandra Multi-Purpose Service
Gulgong Multi-Purpose Service
Gulgong District Hospital
Lourdes Hospital, Dubbo
Mudgee District Hospital
Narromine District Hospital
Nyngan District Hospital
Trangie Multi-Purpose Service
Warren Multi-Purpose Health Service
Wellington Hospital, Bindawalla

Mid-North Coast AHS**Local government areas**

Bellingen, Coffs Harbour, Hastings, Kempsey, Nambucca

Public hospitals

Bellinger River District Hospital
Coffs Harbour Base Hospital
Dorrigo Multi-Purpose Service
Kempsey District Hospital
Macksville and District Hospital
Port Macquarie Base Hospital
Wauchope District Memorial Hospital

Mid Western AHS**Local government areas**

Bathurst regional, Blayney, Cabonne, Cowra, Forbes, Lachlan, Lithgow, Mid-Western Regional (part) Oberon, Orange, Parkes, Weddin

Public hospitals

Bathurst Base Hospital
Blayney Multi-Purpose Service
Bloomfield Hospital
Canowindra Soldiers' Memorial Hospital
Condobolin District Hospital
Cowra District Hospital

Cudal War Memorial Hospital
Eugowra Memorial Hospital
Forbes District Hospital
Grenfell Multi-Purpose Service
Lake Cargelligo Multi-Purpose Service
Lithgow and Integrated Health Facility
Molong District Hospital
Oberon Multi-Purpose Service
Orange Base Hospital
Parkes District Hospital
Peak Hill Hospital
Portland District Hospital
Rylstone Multi-Purpose Service
St Vincent's Community Hospital, Bathurst
Tottenham Hospital
Tullamore Hospital
Trundle Multi-Purpose Service

New England AHS

Local government areas

Armidale-Dumaresq, Glen Innes, Gunnedah, Guyra, Gwydir, Inverell, Liverpool Plains, Moree Plains, Narrabri, Severn, Tamworth Regional, Tenterfield, Uralla, Walcha

Public hospitals

Armidale and District Hospital
Barraba Multi Purpose Service
Bingara Hospital
Boggabri Multi Purpose Service
Glen Innes District Hospital
Gunnedah District Hospital
Guyra and District War Memorial Hospital
Inverell District Hospital
Manilla District Hospital
Moree District Hospital
Narrabri District Hospital
Prince Albert Memorial Hospital, Tenterfield
Quirindi Hospital
Tamworth Base Hospital
Tingha Hospital
Vegetable Creek Multi-Purpose Service, Emmaville
Walcha District Hospital
Warialda District Hospital
Wee Waa District Hospital
Werris Creek District Hospital

Northern Rivers AHS

Local government areas

Ballina, Byron, Clarence Valley, Kyogle, Lismore, Richmond Valley, Tweed

Public hospitals

Ballina District Hospital
Bonalbo Health Service
Byron District Hospital
The Campbell Hospital (Coraki)
Casino and District Memorial Hospital
Grafton Base Hospital
Kyogle Memorial Health Service
Lismore Base Hospital
Macleay District Hospital
Mullumbimby and District War Memorial Hospital
Murwillumbah District Hospital
Nimbin Health Service
Tweed Hospital
Urbenville Health Service

Southern AHS**Local government areas**

Bega Valley, Bombala, Boorowa, Cooma-Monaro, Eastern Capital City Region, Eurobodalla, Goulburn, Greater Argyle, Greater Queanbeyan, Harden, Snowy River, Upper Lachlan, Yass Valley, Young

Public hospitals

Batemans Bay District Hospital
Bega District Hospital
Bombala District Hospital
Boorowa District Hospital
Braidwood Multi-Purpose Service
Cooma Hospital
Crookwell District Hospital
Delegate Multi-Purpose Service
Goulburn Base Hospital
Kenmore Hospital
Mercy Care Centre, Young
Moruya District Hospital
Murrumburrah-Harden
District Hospital
Pambula District Hospital
Queanbeyan District Hospital
St John of God Hospital, Goulburn
Yass District Hospital
Young District Hospital