



**Key Issues
Paper**

S e p t e m b e r 2 0 1 1

**Consultation on draft
Tasmanian Health Organisations Bill**

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Executive summary

In April 2010, the Council of Australian Governments agreed to reform the Australian health system. A National Health Reform Agreement was recently signed and a requirement of that agreement is to establish Local Hospital Networks, which Tasmania will call Tasmanian Health Organisations (THOs).

Legislation has been drafted to support the establishment of three THOs in Tasmania.

THOs will be the service providers and direct managers of public hospital and primary health services currently provided under the Area Health Service model. They will be directly accountable (to the State Government and Parliament) for hospital and health service performance.

The THO legislation will establish the functions and powers of the THOs, their Governing Councils and Chief Executive Officers (CEOs). It will provide for the appointment of Governing Council members and set out the corporate governance requirements that they must abide by.

As required under the National Health Reform Agreement, the proposed legislation will ensure that THOs will be managed independently of the Department of Health and Human Services (DHHS). They will have their own professional Governing Councils, be accountable to the Minister for Health, and have CEOs selected by, and accountable to, the Governing Councils.

The main features of the Bill are:

- the establishment of THOs, including their purpose, functions and powers;
- the establishment and membership of THO Governing Councils, including their functions and powers;
- the operation of THOs, including the role of the CEO, appointment of staff and financial matters;
- that THOs will have ministerial guidance and direction, including the setting of ministerial charters, ministerial policy and directions, and service agreements;
- the requirement for Governing Councils to produce plans and reports, including corporate plans, annual business plans and annual reports; and
- performance management of THOs.

Stakeholder and community consultation

The DHHS National Health Reform Team undertook a statewide consultation process on the draft *Tasmanian Health Organisation Bill 2011*. Consultation sessions were held with clinicians, nurses, departmental staff, key health care stakeholders, other special interest and industry groups and the general community.

The consultation period was open from 9 August to 6 September 2011. During this time, fourteen written responses were submitted from individuals and organisations. Nine consultations sessions were conducted for the general public, DHHS and key stakeholders in Tasmania, with around 120 people attending the sessions. The Minister for Health spoke at the sessions held in each major region and supplementary sessions were conducted by the National Health Reform Team.

This document summarises the main issues raised throughout the consultation process and identifies the common themes that have emerged. It does not attempt to answer every question that has been raised through the consultation process, as individual responses were provided at the consultation sessions and to those who made written submissions.

The nature and range of feedback provided on the draft Bill was varied and the responses can generally be divided into three broad categories:

- 1) Queries resolved by explaining the meaning and interpretation of the legislation;
- 2) Queries resolved by advising that the issue is being dealt with outside of the legislation;
- 3) Queries resolved by advising that the issue will be referred to the legislation drafters.

While the National Health Reform Team attempted to capture all the comments, questions and views expressed at the consultation sessions, it is possible that not every issue has been covered. However, in aggregate, the information recorded, when taken together with the written submissions received, has resulted in the emergence of the key themes outlined below. A record of the consultation session feedback and questions can be found at Appendix A.

For more detailed information regarding the issues raised or responses provided, please contact the National Health Reform Team by emailing health.reform@dhhs.tas.gov.au.

In considering this Key Issues Paper it is important to note that a number of matters under the National Health Reform Agreement still require clarification and are subject to bilateral discussions with the Australian Government. A number of submissions received through the consultation process included issues that are still unresolved and these will be used to inform ongoing discussions.

Finally, the National Health Reform Team would like to thank those who took the time to attend the consultation sessions and who provided written submissions. The questions, comments and views expressed have helped further consideration of the Bill before it goes to Parliament. While there are many different views about how things should be done, the one unifying factor is the passion that people have shown for their health system and its future.

Key themes

The feedback received on the draft *Tasmanian Health Organisation Bill 2011* has encompassed a wide range of opinions and issues, but some common themes have emerged. These themes, listed below in no particular order, relate to the importance of:

- the role of Tasmanian Health Organisations and the Department of Health and Human Services
- the establishment of Governing Councils
- governance around the new structure (reducing bureaucracy/red tape)
- maintaining clinical standards
- planning, funding and delivery of health services
- industrial issues
- local autonomy and community input.

The feedback relating to these themes is explored further on in this document.

Tasmanian Health Organisations and the Department of Health and Human Services

The number of THOs to be established was raised in many of the consultation sessions held. There has been considerable debate and discussion over this issue going back to 2010 when the reforms were first announced.

Some people expressed the view that there should be only one THO, given the current budget situation and also the need to have a statewide focus. Others agreed with the Government's intention to implement three THOs, as this is more consistent with the aim of devolving responsibility for hospital management and giving communities a greater say in how their local hospitals are run, as well as ensuring that services are being delivered based on local needs.

While many have expressed that one THO is appropriate for Tasmania, others have a strong view that there should be three. There are costs and benefits for each option, but ultimately the Tasmanian Government has made the decision that Tasmania will proceed with three THOs. The Bill does provide for flexibility for Government to amend the number and boundaries of THOs in the future.

A few respondents queried why the legislation allows the Governor to increase or decrease the number of THOs or change their boundaries, rather than requiring Parliament to approve changes. The reason behind this is to allow for flexibility if more, less or different THOs are required in the future due to changes in, say, Commonwealth or State policy, health needs or models of care.

A number of participants raised the issue of why the name 'Tasmanian Health Organisations' was chosen in place of what is referred to as Local Hospital Networks under the National Health Reform Agreement. Some people felt that it created confusion and that it needed to be made clearer that THOs will only relate to public hospitals (as opposed to private).

The name 'Tasmanian Health Organisation' has been agreed by Cabinet as it represents the fact that our local hospital networks are more than just hospital networks. The THOs will provide a range of health services, including acute care services and primary health services. The definition in the Bill makes it clear that THOs are public organisations.

There were several comments around the term used to describe who a THO provides its services to. Some people preferred that the terms 'people' or 'patients' be used rather than 'client'. This feedback is being used to amend the terminology included in the purpose, functions and powers sections of THO Bill.

The future role of the Department attracted a lot of attention, particularly whether it would get bigger or reduce in size. There was widespread support for reducing inefficient bureaucracy and red tape and to maximise the amount of money flowing to the frontline services providing patient care. Questions were raised around simplifying the structure to include clear lines of accountability and alignment of accountability of funding provision.

The southern consultation session expressed concern about having the auditor, purchaser and funder all within the Department. Participants were also interested to know what would become of statewide services such as ambulance, mental health and population health, as well as the Human Services part of the Department.

In response, the Department will reduce in size and have a more tightly defined role as a system manager acting on behalf of the Minister for Health. DHHS will be responsible for purchasing health services from the THOs and for monitoring and managing the performance of THOs, as well as system-wide policy. The Minister has advised that DHHS would have a role more alike to a 'ministry of health' and as distinct from THOs as the service providers.

Ambulance Tasmania, the functions of the Director of Public Health, and Human Services will continue to function as they currently do. The governance and funding of these services are not included under the national health reforms.

Statewide and Mental Health Services are currently provided as statewide services, as the name implies. However, the Commonwealth has announced a mental health reform package worth \$2.2 billion in the 2011-2012 Budget, which will result in changes to mental health care in coming years. It is not known what impacts this will have on DHHS and this is an ongoing discussion with the Commonwealth Government. More details are available at www.yourhealth.gov.au

A number of participants around Tasmania commented on the legislation requiring THOs to use certain departmental services, such as business support services. To ensure efficiency and statewide consistency of operations across all THOs as well as DHHS, the legislation requires some services to be provided centrally. The need to maintain centralised business support services such as information technology, human resources, asset management services and finance was recognised at a number of forums, on the grounds that they will ensure statewide consistency and efficiency and support the additional data collection, reporting and accountability requirements associated with the National Health Reform Agreement. However, some questions were raised regarding how the Department will ensure that these services provide high quality and value-for-money services to the THOs. These are legitimate questions and there is no doubt that increased transparency about the quality and cost effectiveness of these services must be provided so THOs know if they are getting value for money. Further work to design effective structures for business support network functions will occur in the lead up to the establishment of THOs.

The establishment and responsibilities of Governing Councils

The establishment and role of Governing Councils were consistent themes that emerged across the state. There was considerable discussion around the purpose, functions and powers of the THOs and their CEOs and Governing Councils.

The CEOs will be appointed as a “head of agency” under the *State Service Act 2000* and will be responsible for the administration and management of the THOs. They will report directly to the Governing Councils.

The Governing Councils will manage the performance of the THOs and ensure that the CEOs are performing their duties effectively and efficiently. The Governing Councils will be required to consult with key stakeholders, ensure that the THOs deliver the commissioned services within budget as agreed in their service agreements, and must act honestly and with care and diligence in performing and exercising their functions, as stated in the THO Bill and other applicable legislation.

The selection process for the chair and members and the criteria that will be used for the selection process was of interest to all consultation sessions.

The chairperson and members of the Governing Councils will be selected through the open selection process that is used to appoint boards of Government Business Enterprises. A selection panel has been formed, comprised of the Secretaries of the Departments of Health and Human Services, Treasury and Finance, and Premier and Cabinet, as well as an independent member. The selection panel will make recommendations to the Minister for Health, who will then make the appointments. The chairpersons will be selected first and then, once appointed, join the selection panel in selecting the members of the Governing Councils. The chairpersons and members will be selected based on their skills and experience in managing complex organisations, health management, business management, financial management, clinical expertise and local health knowledge.

While three Governing Councils will be established, there is potential for a common chairperson or common members to be appointed across the three Councils, given the small pool of applicants who will possess the necessary skill set. The Governing Councils will be fully established by 1 July 2012.

Departmental staff were interested to know if they were eligible to apply to be members of Governing Councils and what remuneration would be provided to members. Other factors raised through feedback included whether Tasmania has the expertise required to fill the chairperson positions on the Governing Councils.

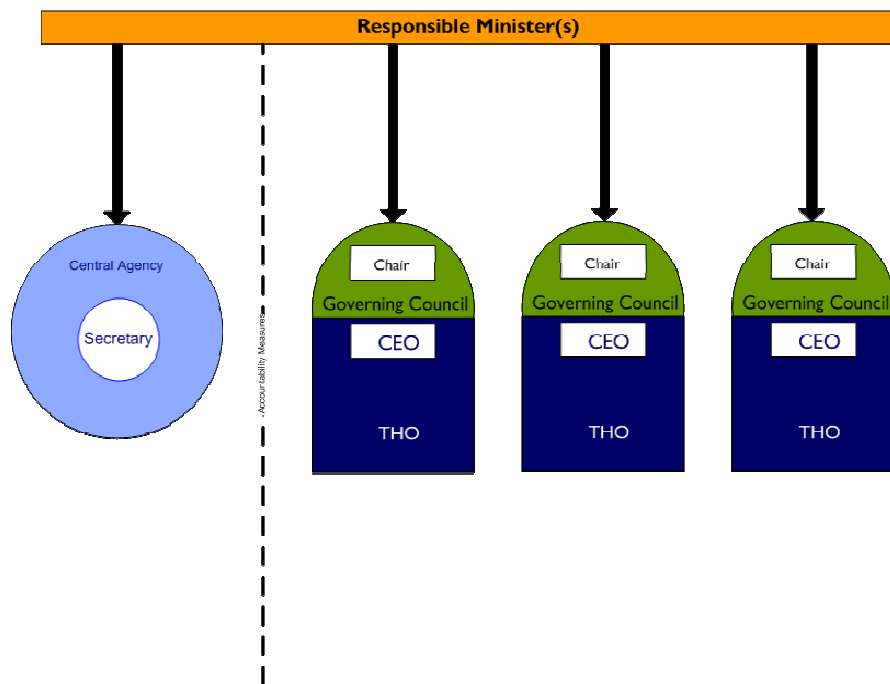
Members will be appointed for a period of not more than three years. It is likely that on the establishment of the Governing Councils, members will be appointed for varying tenures to ensure a staggered rollover of membership over time. The issue of the number of consecutive terms that can be served on Governing Councils is still under consideration.

The National Health Reform Team is working with The Department of Treasury and Finance to develop an induction program for the members of each of the Governing Councils, so that Governing Council members are well briefed and positioned to commence their roles with confidence.

Corporate governance

A number of queries were raised by respondents regarding the corporate governance structure of the THOs. There was some confusion about whether the CEOs report to the Minister for Health or the Governing Councils and whether there would be additional reporting requirements.

The following diagram illustrates the relationships between the Minister, Agency and the Governing Councils and CEOs.



Some people felt that the draft Bill gives too much power to the Minister to intervene in the operations of the THOs. The intent of this is to make sure that the Minister can fulfil her/his role of providing overall management of the health system. Irrespective of the national reforms, the Minister will retain ultimate responsibility for the delivery of public health services in Tasmania and, therefore, must be able to ensure that THOs are performing effectively, efficiently and delivering health services that meet the needs of the Tasmanian community. This does not mean that the Minister will interfere in the day-to-day operations of a hospital or allow the Department to 'micro manage' hospital managers. Put simply, the Minister will determine 'what' will be done, while the THO Governing Councils will have freedom to determine 'how' it will be done.

Most of the measures contained in the Bill that relate to ministerial direction and accountability of the Governing Council to the Minister are adopted from Tasmania's *Government Business Enterprises Act 1995*. This Act establishes public entities that are at arms length from Government when it comes to operational decision making, but ensures that the Government can provide them with broad expectations on behalf of the Tasmanian community. The provisions that are adopted in the Bill are consistent with the requirements of the National Health Reform Agreement and, in fact, provide a greater level of devolution than planned in some other jurisdictions.

In some cases, DHHS staff felt that it would not always be possible to meet the targets negotiated in their service agreement and many were interested to know what would happen if the performance of the THOs became an issue. Linked to this issue were concerns about what happens if there are large, unforeseen events that impact on the THOs' ability to comply with their service agreements.

The service agreements are negotiated documents, so the THO Governing Councils will only agree to the service agreements if they believe these to be achievable. A service agreement should provide challenging

but realistic, achievable performance targets. A service agreement should, however, be flexible enough to deal with most events (e.g. such as higher demand during ‘flu season’). Where there are significantly large events (such as a pandemic outbreak, for example), there are provisions to allow service agreements to be renegotiated.

The Governing Councils and CEOs are responsible for the performance of THOs and will report performance in progress and annual reports. They will also need to submit their corporate plans and annual business plans to the Minister to explain how they plan to meet the requirements of their Ministerial Charter and service agreements. If a THO is not meeting the expectations of its service agreement and corporate plan, the Minister may require the Governing Council to produce a performance improvement plan.

If there are performance concerns, the Minister is also able to appoint a performance improvement team¹ and/or ministerial representative to a Governing Council, depending on the nature of the performance issue. Other than perhaps performance improvement plans, it is unlikely that these measures would be used very often. They should also be seen as assisting, rather than punitive, actions, as in practice these measures provide additional resources to a THO to assist it to overcome a performance issue. The ultimate sanction that can apply is for the Minister to dismiss a Governing Council. While it is hoped that this measure would never be required, it is necessary for the Minister to have this (and the other powers) to protect the interests of the Tasmanian community.

¹ In the consultation draft Bill, the term ‘Corrective Action Team’ is used. Following feedback, the Parliamentary drafter is being requested to amend this term to ‘Performance Improvement Team’.

Primary care and collaboration with Medicare Locals

While not included in the draft THO legislation, a lot of interest was generated around the relationship between THOs and the Medicare Local, particularly the framework for how 'seamless care', primary care and primary health care services will be planned and delivered.

General Practice Tasmania (GP Tas) and the three regional Divisions of General Practice submitted an application to the Commonwealth Government to establish one Medicare Local for Tasmania. This will be known as the Tasmanian Medicare Local (TML) and while it will be a single organisation, there will be three regional branch networks to ensure local responsiveness. The Department and Area Health Services already have a strong working relationship with the Divisions of General Practice which is underpinned by a Memorandum of Understanding.

The exact relationship between the THOs and the TML is still being worked through and will be confirmed once the TML is operational in November 2011. However, the National Health Reform Agreement requires the Commonwealth and State to jointly plan for primary care. A part of this requirement is to develop a General Practice and Primary Health Plan for Tasmania by June 2013, which the DHHS and the TML will work collaboratively on at both a Departmental and local level. A new Memorandum of Understanding between TML, DHHS and the THOs will be developed.

The TML will also work to improve the coordination and integration of primary health care services in local communities. This will be achieved through a regional presence, which will ensure local experience, relevance and responsiveness to the needs of each local community. This will also ensure that the integration of services remains a strong focus of both entities, with improved information sharing and opportunities for collaboration and also the capacity to significantly enhance the relationship between other health sectors.

Appropriate statewide and local mechanisms will be established to further the integration of care. In particular, the Commissioning Unit of DHHS and the TML will need to work collaboratively to ensure coordinated purchasing decisions. There will then be a local level of engagement between the THOs and the TML branch networks. Cross membership of THOs and the TML is possible but at this point in time not considered appropriate, due mainly to the fact the THOs are service providers and the Medicare Local is not (bar some minor exceptions). DHHS is involved in ongoing dialogue with the TML on these issues.

Maintaining clinical standards

Given the large number of clinicians in attendance at consultation sessions, the issue of clinical involvement was a popular point for discussion. Questions were raised in the north of the state about the future of the current clinical networks and how the Tasmanian Clinical Advisory Committee (TCAC) would fit in to the new structure.

While not part of the National Health Reform Agreement, the Commonwealth has made a commitment to establish and fund a national lead clinician group as well as local lead clinician groups, to provide advice to Local Hospital Networks (the THOs) and Medicare Locals. In Tasmania, our local lead clinician group will be known as the Tasmanian Clinical Council (TCC).

The TCAC and Clinical Networks were established as part of *Tasmania's Health Plan*. The Office of the Chief Health Officer recently announced that the majority of clinical networks would not continue due to budget restraints. While the TCC is not a direct replacement of TCAC, it will serve the purpose of providing clinical advice to the three THOs, the TML and the Minister. The TCC is also intended to be an avenue for authoritative clinical advice on the planning of health services. This advice will be considered by the Commissioning Unit within DHHS in planning for the services to be negotiated in service agreements.

Interest was also generated in relation to how the TCC members would be appointed and why there would be just one body created. The intention is to appoint the chairperson and members of the TCC through an open selection process. Members will be selected based on skills and experience as well as regional representation. Current members of TCAC are welcome to express interest in membership of the TCC.

Each THO will also be required to have its own clinical governance arrangements. This will ensure there is local clinical engagement and input into the local delivery of health services.

Given current budget pressures, clinicians were also interested in whether undergraduate clinical placements would still be offered and how this would be funded. The National Partnership Agreement on Hospitals and Health Workforce also includes provisions for maintaining volumes of clinical placements in Tasmania as a key strategy to support workforce planning. As such, THOs will still be required to offer clinical placements for undergraduate health professional students. The Commonwealth Government has also established a statutory authority, Health Workforce Australia, to support health workforce planning in Australia. Health Workforce Australia also offers scholarships to support health professional students to undertake clinical placement, particularly in rural and remote areas. Workforce development will remain a function within the Department, to ensure planning for the future workforce needs of THOs can be managed from a system-wide perspective (this does not override the on-the-ground employment power resting with the THOs' CEOs). Service agreements should lead to more transparent funding arrangements for clinical training.

While not included in the legislation, questions were raised regarding the new hospital accreditation scheme, particularly in relation to the new standards and how they will be implemented. The Commonwealth Government has established the Australian Council on Safety and Quality in Health Care (ACSQHC) as a statutory authority to lead and coordinate improvements in health care safety and quality. The ACSQHC has developed ten standards which focus on clinical safety and quality and are quite different to the standards used under the Australian Council on Healthcare Standards and the Evaluation and Quality Improvement Program, that many hospital staff are familiar with. THOs will be responsible for meeting these standards, which will be phased in from now until 1 January 2013, and the Department will have a regulatory function in monitoring performance against these standards. More information is available on the ACSQHC website - <http://www.safetyandquality.gov.au/>.

Planning, funding and delivering health services

During the consultation period, many questions were raised regarding the commissioning process and transition to activity based funding (ABF). The consultation sessions and feedback received also elicited several questions about commissioning, such as the role of the Commissioning Unit, how the commissioning process will work and how they negotiate the service agreement with the THOs.

The Commissioning Unit has been established within the Department and the primary purpose will be to commission health services and health support services from the THOs. The Commissioning Unit will work with THOs to determine the scope and volume of health services which the THOs provide to the Tasmanian community. Through this negotiation process, the Commissioning Unit will also work out the funding allocation for each THO to deliver each health service.

In relation to the funding of health services, participants were interested to know how the efficient price will be determined and who will be responsible for calculating it. Questions were also raised about which services it will apply to and how it will be implemented.

Under the National Health Reform Agreement, the Independent Hospital Pricing Authority (IHPA) will be established. This statutory authority will determine the 'national efficient price' for hospital services that can be funded by activity. That is, the IHPA will determine the efficient cost of delivering a range of health services that are considered 'hospital' services.

This 'price' will be used to work out how much funding each hospital will receive based on the number of services commissioned for each particular type of health service that is activity funded. There is the capacity for loadings to the 'efficient price' to reflect regional variations in the costs of providing services.

The majority of hospital services will have an efficient price, and so the amount of funding will be determined by the activity and number of services provided by the hospital. Services that are intended to be funded based on activity include elective admissions, emergency admissions, subacute care, outpatients and mental health care.

The introduction of ABF will be phased in from 2012-13 and negotiations are still occurring with the Commonwealth with regard to the proportion of its funding contribution that will be made on an ABF basis, and the proportion that will continue to be block funded. These proportions, once agreed, will be subject to change over time (particularly as more services move to an ABF basis).

A number of questions were also raised about funding for services that that will not be funded by activity, particularly teaching, training and research. The consultation sessions in the north also generated a lot of discussion around funding for rural hospitals. Of particular concern was the viability of these hospitals if they were to be funded on an activity basis.

The National Health Reform Agreement recognises that some hospital services are either impractical or unsustainable if funded on an activity basis. Similarly, funding for teaching, training and research will be block funded based on what it costs to deliver the service as a whole.

The National Health Reform Agreement also recognises that some hospitals services will not be able to be delivered at an efficient price in some areas because they are unable to achieve economies of scale. In these cases, block funding (or Community Service Obligation payments) will be made. In Tasmania, all of our rural hospitals are likely to fall into this category (e.g. only the three major hospitals will be funded on an ABF basis).²

² The Mersey Community Hospital is subject to its own funding arrangement with the Commonwealth Government as this continues to be a Commonwealth-owned hospital).

A number of questions were also raised about how capital planning, procurement and maintenance will work in the new structure and how much input the THOs will have around these issues. This issue is still under consideration. There is a case to devolve some capital management to THOs to ensure efficiency and timely decision making for those that use the capital. However, there is also a need to have a system-wide capital management approach. What is likely to result is a balance where some capital is at the discretion of THOs to manage ('operational' capital, such as equipment for example), while 'large' capital items (including buildings) will be managed by the Department, but through a consultative process with THOs.

Several questions were raised regarding who will pay for patient transfers if a patient is transferred from one hospital to another. Funding for patient transfers will remain with Ambulance Tasmania. The THO that is transferring the patient will be responsible for organising the patient transfer with Ambulance Tasmania. Patient travel assistance and interstate charging costs are likely to be the responsibility of the sending hospital and funding for services provided should follow the patient.

Negotiation of the service agreements and THO budgets

Given that the service agreements will determine the activities that each THO will undertake, there was a lot of interest in the process around how the agreements will be negotiated and who will determine what is to be included.

The Commissioning Unit will analyse population data to assess health needs to guide the commissioning of health services from THOs. It will also take into account clinical advice and community and consumer input.

The end product of the commissioning process will be service agreements which will clearly outline what is being purchased from each THO and the budget that will be provided and will also clearly outline the performance expectations. While the Commissioning Unit will negotiate with the THOs on the service agreements, it will be the Minister who signs the agreements. The negotiation process will be an iterative one over a period of time, and must be finalised before the commencement of the financial year to which the service agreements will apply. This is a significant change to the way Area Health Services currently receive their budgets, which is after the financial year has commenced.

In the unlikely event that the Minister and Governing Council cannot agree to a service agreement, the terms of the service agreement will be determined by the Minister. This is to ensure services will continue to be funded and delivered (a service agreement is necessary to provide a budget to a THO, to allow it to pay its wages, invoices and other expenses).

The consultation process across the state raised several questions about how funding will be allocated for services that are only delivered in particular areas, i.e. cardiothoracic and neurosurgery. Under the new model, the provision of some services at particular sites will continue to ensure THOs are working within the broader Tasmanian Health system and as such, some members of the Tasmanian community will still be required to travel to a different hospital to receive the care they need. In determining funding for these types of services, the Commissioning Unit will consider the demand across the whole Tasmanian population, and then fund the THO(s) responsible for delivering these services to that level, and not just for their share of the population, so no THO will be disadvantaged for delivering services to patients who do not live in their area.

Industrial issues

Many of the consultation sessions targeted current Area Health Service (AHS) staff. Staff were very keen to hear about industrial issues associated with transitioning to the THO model, including employment conditions and the negotiation of future enterprise bargaining agreements. Given the change in structure, people were also keen to know who would be responsible for recruitment of hospital staff.

The CEO of each THO will be appointed as a Head of Agency by the Minister, upon recommendation from the Governing Council. This provision within the legislation has been made primarily so that THO staff can continue to be employed under the *State Service Act 2000*.

As THO staff will continue to be employed under the *State Service Act 2000*, they will retain all award and enterprise agreement conditions including salary, classification, leave entitlements and RBF superannuation. If staff are currently eligible for salary packaging, this will also continue.

The current recruitment and selection processes will continue to apply to THOs as all future staff will also be employed under the *State Service Act 2000*.

To maintain statewide consistency and equity between THOs and staff employed in the Department, future industrial awards and enterprise agreements for both THOs and DHHS staff will be negotiated with the unions by the Department on behalf of the THOs.

The majority of staff employed in the Area Health Services and the Business Services Network will not be affected by the transition to THOs. The roles and functions of a small cohort of staff will change in the transition to activity based funding. In these cases, staff and their managers will work through the details with the help of Human Resources and the unions.

The issue of communicating the changes that will occur in the transition period and the change management plan that will be put in place was also a key concern, particularly for hospital staff.

While the Department will provide support and information and undertake some roles in this process, it will also be essential for change to be led from within the Area Health Services as they transition to THOs. One of the initial tasks for the incoming Governing Councils will be to ensure there is a successful transition and to provide the leadership necessary to make the cultural, process and system changes that will be needed.

Under the National Health Reform Agreement, the THOs have to be fully operational by 1 July 2012. The Commissioning Unit has been established and the appointments for the Governing Council chairperson positions will commence shortly.

The National Health Reform Team is available to provide more information and regular updates will also be posted on the National Health Reform webpage on the DHHS internet at www.dhhs.tas.gov.au/healthreform

Local autonomy and community engagement

Although not included in the draft THO legislation, a number of queries were raised regarding consumer and community engagement by THOs and the Department. Community engagement is currently not explicitly included in the legislation; however, a small number of people felt that it should be included. Others varied in their opinion on how stronger local input can be best achieved. Some felt that there should be community or consumer representation on the Governing Council.

While the Bill does not specify a process, it is intended that consumer and community input be a key requirement for THOs and the Commissioning Unit. The aim is to ensure consumer and community input into the planning of services, and in monitoring how well those services are delivered. Discussion with the Parliamentary drafter is occurring to consider how this role might be strengthened in the Bill.

Appendix A

Southern Tasmania session – Clinical School

17 August 2011

- Is this the same as State-wide services in that it's owned by one THO but still delivered in other areas?
- Who will direct which services are handled each way? Will this be the Department or the THOs?
- Will THOs have a say in what services they deliver?
- Should agreement not be reached on the Service Agreement, will the THO just be told what the agreement is?
- Is there a conflict between having the auditor, funder and purchaser all in the same Department?
- Will decisions still be overturned due to the political environment? How can this be protected if the Commissioning Unit is in the Department?
- Where do the clinical networks fit into the new system?
- Will there be an opportunity for lower level clinical input into state-wide policies eg: coordination templates, simplified resources for standardisation?
- Are the Chairs of Governing Councils going to be paid?
- Will State Service employees be paid if they are a member of a Governing Council?
- Will both current and new staff remain under the State Service Act?
- Does the CEO report to the Minister or the Board?
- Who will be the employee's Head of Agency?
- Where is the articulation for workforce development and the education sector?
- Does this include Human Services or will the Department be split into two?
- There is currently a level of commonality between people who work within Health and Human Services. Will this change?
- How will the Commissioning process work?
- How much flexibility is there for contingency? For example if there was a H1 breakout in a hospital, all the ABF would dry up as a result. Would an event like this allow the hospital to break their service agreement?
- How does health promotion and illness prevention fit in?
- Has there been consideration of institutionalising community engagement into THOs/Legislation?
- Can we afford three Governing Councils?
- Will the accountability and control be mapped out? For example, a commitment to workforce profiles – EBAs will be negotiated centrally but THOs are responsible for labour costs.
- Issues with asset management being centralised. How can we be responsible for something we don't have control over? Access to facilities is needed to perform day to day operations and this will mean that any adaptability or flexibility will be removed from THOs.
- Does the increase in transparency mean additional layers of reporting?

Northern Tasmania session (afternoon) - LGH

23 August 2011

- Who decides which AHS provides each service?
- Will the state-wide policy system remain in the Department?
- Quality and Safety is managed at the Dept level. How will this evolve out to THOs and is there an agreement that specifies this?
- How will the collaboration with the Medicare Local happen and what will this mean from a systems perspective?
- Where will Education and Training fit into the new structure?
- Will there be a review the TCAC Board in terms of membership and Terms of Reference?
- What elements of Primary Health are going to THOs?
- What are the transition arrangements given the current budget situation?
- Will Governing Council positions be full time?

- Is there a process for the selection of Governing Councils?
- There will be a risk with ABF in region in terms of transferring patients. How will we ensure that cost isn't an inhibitor to doing this?
- Is the funding model based on DRGs?
- Will the central Agency get bigger or smaller?
- What will the Agency do in terms of change processes to make the transition happen, especially for people on the ground?

Northern Tasmania session (evening) – LGH
23 August 2011

- Why was the THO name chosen?
- Is there still going to be one state-wide clinicians group, as you would think each THO would have their own clinical body?
- Will the THOs have to pay money towards the Independent Hospital Pricing Authority that is being established?
- Will the efficient price be the same Australia wide?
- Will adjustments be made to a service agreement prior to issues arising or after?
- Historically ABF has been based on elective surgery but more than half the work we do at the moment is acute. Does the current ABF model address this issue?
- Will ABF look at everything a hospital provides or just the elective surgery component?
- It is important that consideration is given to overall hospital activity rather than just individual areas.
- It sounds like the LGH will be disadvantaged given they are the tertiary hospital for two North West hospitals. Will we be penalised because we aren't getting to elective cases at the LGH because we are getting all the non-elective North West patients to treat?
- The targets aren't realistic, so no hospital will be able to get federal funding.
- It is a different situation here in Tasmania because we can't bypass things like other states can.
- The additional budget pressure seems to be contradicting how these reforms will be implemented.
- How will training and education be funded in THOs?
- How will this improve non-urgent cases?
- Getting access to the system is getting harder and none of the reforms seem to address this.
- The solution to seeing more patients is to employ more doctors and that's not possible.
- There seems to be a lot of committees being created to consider waiting times but nothing to provide solutions on how to fix them.
- To meet the required targets we are going to have to manipulate the front end of the system.
- Will procurement be any different under the new system? An example of inefficiency is repairing a piece of equipment 9 times at the cost of \$6,000 each time when a new one would have only cost \$5,000. Whose decision will it be to purchase equipment?
- Who will be responsible for recruitment in hospitals?
- Forecasting a budget a year in advance is going to be difficult. What happens if we forecast 100 new hips but we are presented with 150 cases?
- If your service agreement says you aren't to perform vascular surgery, does that mean you can't employ a vascular surgeon?
- So the State-wide Lead Clinicians Groups is going to suggest what is appropriate for each region?
- Will the CEO have more power and will they be responsible for hiring and firing?
- Who will be making capital decisions and how will funding be attached to it?
- Capital operational equipment has previously been a problem as there has been no account for the replacement of machinery. Will we have to continue writing business cases to get things replaced?
- Who appoints each CEO?
- Does the Minister have to accept the recommendation of the Governing Council for the CEO?
- What is the liability for being a member of a Governing Council?
- Is there anything in the Legislation that specifies which services have to be used?
- Do THOs have to use certain service providers or can they look at cheaper options that might be outsourced?

- Is there provision for charging between THOs for services eg: patient transfers?

Northern Medical Staff Association - LGH

24 August 2011

- Will the Governing Councils be full time?
- What is meant by purchasing services?
- Will the Board obtain a number that equates to particular services?
- Is the CEO also the Chair of the Governing Council?
- Will there be a penalty for doing fewer hips than what was forecasted in the service agreement?
- What happens if you do more hips than what you had forecasted?
- Is the fact that we don't get paid for the exact number of hips we do, part of the Commonwealth or State Legislation?
- What would be the economic response to a Swine Flu outbreak?
- Is there going to be a separate model for elective predictability versus non-acute cases?
- If there are extra cases than what was predicted, does the THO have to find the money from within rather than receiving additional funding?
- So the service agreement is going to be based on the previous year's activities in order to establish predictions for the next year?
- How will new service provision work?
- So the purchaser of services will be an arm of the Department?
- What will be the difference between the historical budget and the forecasted budget?
- Is the service agreement going to be negotiated under good will?
- How are the grand rules going to be set and what will be the power structures?
- If there is insufficient funding that causes a situation, how will that be worked out at a practical level and what changes will be put in place to fix this?
- Who will negotiate the hospital funding, will that be the provider and funder based on the number of DRGs?
- Will the Board be an intermediary between the THO and purchaser?
- Will the current CEOs remain in their positions?
- Will staff entitlements change under the new system?
- How will teaching and training get funded and will it be included in the service agreement?
- What happens with the IT services that are currently delivered state-wide?
- Could we purchase IT services from elsewhere if it was more efficient to do so?
- Who will pay for patient transfers?
- Do the Governing Councils have statutory responsibilities and a code of conduct?
- Will the Governing Council report down ways as well as up ways eg: would the Council report to the Medical Staff Association?
- Will Activity funding cover depreciating equipment?
- Will equipment purchasing still be centralised?
- Is infection control part of the block funding that a THO will receive?
- Will the choice to appoint specific physicians and what to pay them be the THOs decision?
- What happens if the THO makes a profit at the end of the year; do we get to keep it?

North West Tasmania session – Mersey Community Hospital

25 August 2011

- What will happen if some hospitals decide to stop certain services because they are not efficient or funded adequately for them? This will lead to a negative impact on patients.
- In some cases we need to look at spending some money in order to make long term gains. Will there be any additional money to do this in order to improve innovation/efficiency?
- What Communications program will go with the implementation of the reforms and the transition period? You really need to get in at the bottom and sell the benefits of the reforms.
- Is there a risk that a hospital will be reluctant to do procedures that are costly?

<ul style="list-style-type: none"> • What happens if patients are referred to another hospital? • There is a high locum usage in the North West. What will be the budget set up under the new system and will there be flexibility for staffing in respect to locums? • Will the Governing Councils be operating before the 1 July 2012? • How will it be ensured that the THOs and Medicare Locals are working together collaboratively? • What happens with GP patients presenting at hospitals? People on low incomes prefer to go to Emergency Departments because they are not billed when they go there in comparison to their GP. • Will there be more options for people after hours to help alleviate Emergency Department demand? 	
<p>North West Tasmania session - NWRH</p>	<p>25 August 2011</p>
<ul style="list-style-type: none"> • Who appoints the members of the Governing Council? • What is the tenure of members? • Will Board members be paid? • Will the Board be responsible for the CEO's decisions? • How will the Medicare Local talk to THOs? • Will the CEO be responsible for hiring and firing or will that be the Boards responsibility? • Not everything can be factored into ABF. What happens to the prevention activities that activity can't be measured against? • Will the health reforms have any impact on the Heads of Agreement for the Mersey Community Hospital? • What is the relationship between the Medicare Local and Primary Health? • What will happen to Population Health and other areas looking after health prevention? • Will all Primary Health elements come under the Medicare Local? 	