



A HEALTHIER FUTURE FOR ALL AUSTRALIANS

FINAL REPORT JUNE 2009





Australian Government
National Health and Hospitals
Reform Commission

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A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission – June 2009

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Australian Government
National Health and Hospitals
Reform Commission

30 June 2009

The Hon Nicola Roxon MP
Minister for Health and Ageing
Parliament House
CANBERRA ACT 2600

Dear Minister

It is my great pleasure to present the Final Report of the National Health and Hospitals Reform Commission.

A Healthier Future For All Australians: Final Report is the culmination of 16 months of discussion, debate, consultation, research and deliberation by a team dedicated to the cause of strengthening and improving our health system for this and future generations of Australians.

We acknowledge the many people who contributed to our work through consultations and submissions – including governments, health professionals and other experts, health and consumer interest groups, and members of the general community.

Our Final Report builds on the work of our two earlier reports – *Beyond the Blame Game* (April 2008) and *A Healthier Future For All Australians: Interim Report* (December 2008). With the needs and interests of the Australian people at the centre of our thinking, our reform agenda urges action to:

- Tackle the major access and equity issues that affect people now;
- Redesign our health system to meet emerging challenges; and
- Create an agile, responsive and self-improving health system for future generations.

We present more than 100 recommendations to transform the Australian health system. Some will have an immediate impact; others will take time to implement; and still others are for further development.

Health reform does not happen overnight. It takes time and patience, commitment and goodwill from all of us. But we also believe that there is a pressing need for action, and health reform must begin now.

My fellow Commissioners and I have been privileged to be part of this historic opportunity. We thank you for entrusting us with this important work.

We commend our report to you and the Government in the hope that our efforts will contribute to a sustainable, high quality, responsive health system for all Australians now and into the future.

Yours sincerely

A handwritten signature in black ink that reads "Christine Bennett".

Dr Christine Bennett
Chair
National Health and Hospitals Reform Commission

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EXECUTIVE SUMMARY



EXECUTIVE SUMMARY

Taking action

A Healthier Future For All Australians – the final report of the National Health and Hospitals Reform Commission – provides the governments of Australia with a practical national plan for health reform that will benefit Australians, not just now but well into the future.

The case for health reform is compelling.

The health of our people is critical to our national economy, our national security and, arguably, our national identity. Our own health and the health of our families are key determinants of our wellbeing. Health is one of the most important issues for the Australian people, and it is an issue upon which they rightly expect strong leadership from governments.

While the Australian health system has many strengths, it is **a system under growing pressure**, particularly as the health needs of our population change. We face significant challenges, including large increases in demand for and expenditure on health care, unacceptable inequities in health outcomes and access to services, growing concerns about safety and quality, workforce shortages, and inefficiency.

Further, we have a **fragmented health system** with a complex division of funding responsibilities and performance accountabilities between different levels of government. It is ill-equipped to respond to these challenges.

We believe we can do better, and now is the time to start.

This report identifies actions that can be taken by governments to reform the health system under **three reform goals**:

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

Tackling major access and equity issues

Equity, or 'fairness' to use everyday language, must be at the heart of the Australian health system. In our report we focus on **five priorities for improving access and equity**.

Improving health outcomes of Aboriginal and Torres Strait Islander people

Our first priority acknowledges the unacceptable health outcomes of Aboriginal and Torres Strait Islander people. To address this, we are recommending a radical change to how we take responsibility for improving the health of our first Australians. We want all the funding for Aboriginal and Torres Strait Islander people to be aggregated. We want a new **National Aboriginal and Torres Strait Islander Health Authority (NATSIHA)** to take this funding and actively purchase and commission the very best health services – services that are effective, high quality, culturally appropriate and meet the needs of Aboriginal and Torres Strait Islander people, their families and their communities.

Further, we want this Authority to demand and **hold all health services to account** for providing the right services for Aboriginal and Torres Strait Islander people. This also means that we need to **invest more** than we do now, so that the Authority can ensure that spending actually matches their greater health needs. This will be critical in helping 'close the gap' in health outcomes between Aboriginal and Torres Strait Islander people and other Australians.

Poor nutrition – particularly low fruit and vegetable intake – is an important determinant of the health gap among Aboriginal and Torres Strait Islander people. But many are living in remote areas with limited access to affordable healthy foods. To help tackle this, we are recommending an integrated package to **improve nutrition in targeted remote Indigenous communities**.

We must also strengthen the vital role of Community Controlled Health Services, **train and recognise an Indigenous health workforce and a workforce for Indigenous health**, and up-skill our health workforce to provide culturally appropriate services.

Improved care for people with serious mental illness

Our second priority for improving access and equity is **better care for people with serious mental illness**. We set out ways to ensure there is a range of treatment and support services for people with a mental illness, connected across the spectrum of care. We recommend an expansion of sub-acute services in the community and propose that all acute mental health services have a 'rapid response outreach team', available 24 hours a day, which can provide intensive community treatment and support, as an alternative to hospital-based treatment.

Support for people living in remote and rural areas

The recommendations under our third priority are directed at addressing the problems for **people living in remote and rural areas** of having a universal health entitlement under Medicare, but not gaining universal access due to the limited availability of doctors in remote and rural communities.

We are proposing that under-served remote and rural communities be given 'top-up' funding to an **equivalent amount of funding** on a per capita basis as communities with better access to medical, pharmaceutical and other primary health care services. We are also supporting increased funding for patient travel and accommodation, strategies to improve health workforce supply, and clinical training opportunities in remote and rural areas.

Improved access to dental health care

Improving **access to dental health care** is our fourth key priority for improving access and equity. Nearly one third of all Australian adults avoid or delay visiting the dentist due to costs; there are more than 650,000 people on public dental waiting lists; and the dental health of our children is worsening.

To address these problems, we are recommending a new universal scheme for access to basic dental services – **'Denticare Australia'**. Under Denticare Australia, everyone would have the choice of getting basic dental services – prevention, restoration, and the provision of dentures – paid for by Denticare through either a private health insurance plan or through public dental services. We are also recommending **internships for graduating dentists and oral health professionals** to provide broader clinical experience and training, as well as to expand the public dental workforce.

To improve the **dental health of Australia's children** we are recommending the national expansion of preschool and school dental programs.

Timely access to quality care in public hospitals

Our fifth priority is to take action now to **improve timely access to quality care in public hospitals**, particularly care in emergency departments and access to planned surgical and medical care.

We recommend that **public hospitals with major emergency departments be funded to ensure beds are available** at all times for people needing to be admitted from the emergency department. For patients, this would mean quicker access to a hospital bed in an emergency and less crowded emergency departments with care being provided more quickly and safely.

Waiting times for planned surgical and medical care in public hospitals have increased over the last few years. The Commonwealth Government has committed \$150 million annually up until 2010–2011 to reduce waiting lists. We propose extending this additional funding beyond 2010–2011. We are also recommending **extra funding** to address unmet need that will present once existing waiting lists are cleared.

National Access Targets

In addition to directly addressing these five priorities for improving equity and access, we believe it is vital that we continuously measure and report on whether people are accessing the health services they need in a timely manner. We are recommending **National Access Targets across the continuum of health services** – including primary health care services, mental health services, aged care assessment, public hospital outpatient services, radiotherapy, planned surgery and emergency departments. We want the targets to be developed through broad community consultation, incorporating clinical, managerial and financial perspectives.

Redesigning our health system to meet emerging challenges

Our second goal for reforming the health system aims at **fundamental redesign** that will allow us to better respond to emerging challenges. It is based on three design elements.

Embed prevention and early intervention

The first design element is to **embed prevention and early intervention** into every aspect of our health system and our lives.

Key to this is the establishment of an independent **National Health Promotion and Prevention Agency**. The Agency should have a broad role to drive a fundamental paradigm shift in how Australians, and our health system, think and act about health and keeping well, including through better education, evidence and research.

Our recommendations related to prevention and early intervention focus on children and young people. The evidence is overwhelming. If we act early, we can prevent or reduce the magnitude of many disabilities, developmental delays, behavioural problems and physical and mental health conditions.

Our recommendations for **a healthy start to life** involve ensuring that children and parents – and potential parents – get access to the right mix of universal and targeted services to keep healthy and to address individual health and social needs.

We also have a particular focus on encouraging **good mental health in young people**. Most new cases of what become chronic mental illnesses – including psychotic disorders such as schizophrenia – emerge in late adolescence and the early adult years. We are recommending the national implementation of youth-friendly, community-based services providing information and screening for mental disorders and sexual health, and specialist clinical services for prevention of, and intervention for, early psychosis.

Connect and integrate health and aged care services

The second element in redesigning the health system to meet emerging challenges is to **connect and integrate health and aged care services** for people over the course of their lives.

Currently our health system works reasonably well if people have acute or emergency problems that can be quickly resolved through one-off medical interventions. However, the needs of people living with chronic diseases, people with multiple complex health and social problems, and older, increasingly frail people are less well met.

We need to **redesign health services around people**, making sure that people can access the right care in the right setting.

To do this, we argue strongly that **strengthened primary health care services** in the community should be the 'first contact' for providing care for most health needs of Australian people. This builds upon the vital role of general practice. We want to create a platform for comprehensive care that brings together health promotion, early detection and intervention, and the management of people with acute and ongoing conditions. Our key recommendations to support this are:

- bringing together and **integrating multidisciplinary primary health care services**, with the Commonwealth Government having responsibility for the policy and government funding of primary health care services that are currently funded or managed by state, territory and local governments;
- improving access to a more comprehensive and multidisciplinary range of primary health care and specialist services in the community, through the establishment of **Comprehensive Primary Health Care Centres and Services**, which would be available for extended hours;
- encouraging better continuity and coordinated care for people with more complex health problems – including people with chronic diseases and disabilities, families with young children, and Aboriginal and Torres Strait Islander people – under voluntary enrolment with a **'health care home'** that can help coordinate, guide and navigate access to the right range of multidisciplinary health service providers;
- establishing **Primary Health Care Organisations** to support better service coordination and population health planning, by evolving from or replacing the current system of Divisions of General Practice; and
- promoting **better use of specialists in the community**, recognising the central role of specialists to the shared management of care for patients with complex and chronic health needs.

We also argue strongly for the need to create 'hospitals of the future' and to expand speciality services in the community as part of connecting and integrating health care.

Our recommendations around **reshaping hospitals** involve separating the provision of elective and emergency services in public hospitals to provide better access to, and efficient delivery of, planned surgery and procedures.

We also recommend a **review of public hospital outpatient services** to ensure that they are more closely designed around the needs of patients, including providing more of these services in community settings outside hospitals.

There is also an urgent need for **substantial investment in, and expansion of, sub-acute services** – the 'missing link' in care – including a major capital boost to build the facilities required.

Further, we need to build the capacity and competence of primary health care services to provide generalist **palliative care support** for their terminally ill patients, supported by additional investment in specialist palliative care services to allow better access to care for people at home.

Our recommendations on **aged care services** are an important part of connecting and integrating health and aged care services. They seek to balance three goals in repositioning our aged care services:

- ensuring greater choice and responsiveness for consumers;
- getting the most effective use of public monies while protecting those older people who are most in need; and
- creating an environment that fosters a robust and sustainable aged care sector.

'Next generation' of Medicare

The third design element in redesigning the health system to meet emerging challenges is concerned with the **'next generation' of Medicare**. There are four important points here.

First, the Commonwealth Government will be responsible for bringing together state-funded primary health care services and medical services under Medicare **to create a comprehensive primary health care platform**. This will include a focus on promoting good health, early intervention and better managing chronic disease.

Second, the Commonwealth Government will need to consider the **scope of services under the 'universal service entitlement'** in a 'next generation' Medicare. The broader range of services included could be funded through a range of different payment mechanisms involving, for example, a mix of salary, fee-for-service, grants, payments for performance and quality, and payments for episodes of care.

Third, we have recommended that the scope and structure of existing **safety net arrangements be reviewed**. There are currently multiple safety nets and a patchwork of government programs that partially meet the costs of some services. We need a simpler, more family-centred approach that improves the affordability of health care.

Fourth, we have recommended that in **reshaping the Medicare Benefits Schedule** (one core element of the 'next generation' of Medicare), the Commonwealth Government must first decide the scope of services to be included. A framework is then needed to define the competency and scope of practice within which health professionals can provide certain services. This reshaping should be driven by a robust evidence base, and also promote continuity and integration of care through collaborative team models of care.

Creating an agile and self-improving health system

In our third goal for reforming the health system we are calling for the **creation of an agile and self-improving health system** for long-term sustainability. Our recommendations are grouped under five levers of reform to support a system adaptive and responsive to changing needs.

Strengthened consumer engagement and voice

The first lever is **strengthened consumer engagement and voice**. Consumer engagement is encouraged by:

- **building health literacy** – for example, by including health literacy as a core element of the National Curriculum for schools;
- **fostering community participation** – for example, through citizen juries on issues such as the allocation of scarce resources among competing priorities; and
- **empowering consumers** to make fully informed decisions, for example, on choice of aged care services.

Modern, learning and supported workforce

The second lever is a **modern, learning and supported workforce**. Here we recommend:

- **fostering clinical leadership and governance**, including through the establishment of 'clinical senates' at national, regional and local levels to contribute to clinical service planning;
- developing a new **framework for the education and training of our health professionals** which moves towards a flexible, multi-disciplinary approach, and incorporates an agreed competency-based framework as part of a broad teaching and learning curriculum for all health professionals;
- a **dedicated funding stream for clinical placements** for undergraduate and postgraduate students, providing for clinical training supervision and infrastructure to be available across all health settings – public and private – including hospitals, primary health care and other community settings; and
- the establishment of a **National Clinical Education and Training Agency** which would advise on the education and training requirements; purchase clinical education placements; promote innovation; foster local implementation models; and report regularly on the appropriateness of professional accreditation standards.

Smart use of data, information and communication

Our third lever to support an agile, self improving system is the **smart use of data, information and communication**.

We are recommending a **transforming e-health agenda** to drive improved quality, safety and efficiency of health care.

The introduction of a **person-controlled electronic health record for each Australian** is one of the most important systemic opportunities to improve the quality and safety of health care, reduce waste and inefficiency, and improve continuity and health outcomes for patients. Giving people better access to their own health information through a person-controlled electronic health record is also essential to promoting consumer participation, and supporting self-management and informed decision-making. We want the Commonwealth Government to legislate to ensure the privacy and security of a person's electronic health data.

Making the patient the locus around which health information flows is critical and will require a major investment in the broader e-health environment. Electronic health information and health care advice will increasingly be delivered over the internet. **Broadband and telecommunication networks** must be available for all Australians if we are to fulfil the real promise of e-health.

We are also recommending that **clinicians and health care providers are supported to 'get out of paper'** and adopt electronic information storage, exchange and decision support software. The Commonwealth Government must set open technical standards which can be met by the vendor industry while ensuring the confidentiality and security of patient information. Most importantly, we urge governments to expedite agreement on a strengthened national leadership structure for implementing a **National Action Plan on E-health**, with defined actions to be achieved by specified dates.

Access to good information is also vital to measuring and monitoring the health of our population. We are recommending the development of **Healthy Australia Goals 2020** – the first in a rolling series of ten-year goals. We want all Australians to participate in setting these goals and working towards improvements in health outcomes at local, regional and national levels.

We are also keen to promote a culture of continuous improvement through **health performance reporting**. Our recommendations include:

- systems to provide comparative clinical performance data back to health services and hospitals, clinical units and clinicians;

- publicly available information on health services to assist consumers in making informed choices;
- the Australian Commission on Safety and Quality in Health Care to analyse, report and advocate on safety and quality across all health settings; and
- regular reporting on our progress as a nation in tackling health inequity.

Well-designed funding and strategic purchasing

The next lever for reform is well-designed **funding and strategic purchasing** models, particularly to better respond to people's care needs over time.

Encouraging collaborative, multidisciplinary teams and supporting voluntary enrolment will require the **use of blended funding** models. We are recommending that in the future primary health care would receive funding that comprises ongoing fee-for-service payments, grant payments to support multidisciplinary clinical services and care coordination, outcomes payments to reward good performance, and episodic or bundled payments.

The development of **episodic payments** will not happen overnight, nor would they be applicable to all patients. But the use of episodic payments would create greater freedom for primary health care services to take a long-term, whole person and population health perspective that moves away from funding on the basis of single consultations or visits – an approach that can better meet the needs of people with chronic and complex conditions.

To improve the efficiency of both public and private hospitals we are recommending introducing the use of **efficient 'activity-based funding' for hospitals** using casemix classifications. Activity-based funding refers to making payments on the basis of 'outputs' delivered by health service providers, such as a hospital admission, an emergency department visit or an outpatient consultation. Activity-based funding explicitly links funding to the actual services provided. It allows funders to compare the costs across different health service providers (such as hospitals) in providing the same health service (such as a hip operation).

Knowledge-led continuous improvement, innovation and research

Our fifth lever for reform is **knowledge-led continuous improvement, innovation and research**. We believe that our future health system should be driven by a strong focus on continuous learning and the implementation of evidence-based improvements to the delivery and organisation of health services. Our reforms seek to embed continuous improvement, innovation and research through **actions targeted at both the national level and at the local level of individual health services**, including by:

- making the Australian Commission on Safety and Quality in Health Care a permanent national organisation;
- strengthening the role of the National Institute of Clinical Studies in disseminating evolving evidence on how to deliver safe and high quality health care;
- investing in health services, public health, health policy and health system research, including ongoing evaluation of health reforms;
- funding clinical education and training through dedicated 'activity-based' payments; and
- establishing clinical research fellowships across hospitals, aged care and primary health care settings so that research is valued and enabled as a normal part of providing health services.

Reforming governance

To ensure Australia's health system is sustainable, safe, fair and agile enough to respond to people's changing health needs and a changing world, we need to make significant changes to the way it is governed. We make two main recommendations on reforming the governance of our health system.

Healthy Australia Accord

The first recommendation calls on First Ministers to agree to a new **Healthy Australia Accord** that clearly articulates the agreed and complementary roles and responsibilities of all governments in improving health services and outcomes for all Australians. The Accord retains a governance model of shared responsibility for health care between the Commonwealth and state governments, but with significantly re-aligned roles and responsibilities.

The new arrangements provide for:

- shifting Australia's health system towards '**one health system**', particularly by defining a range of functions to be led and governed at the national level to ensure a consistent approach to major governance issues, such as workforce planning and education, and e-health;
- realigning the roles and responsibilities of the Commonwealth and state governments, with the **Commonwealth having full policy and government funding responsibility** for primary health care, basic dental care and aged care, as well as responsibility for purchasing health services for Aboriginal and Torres Strait Islander people; and
- **changing the funding arrangements for public hospitals and health care services**, with the Commonwealth Government paying the state governments activity-based benefits for public hospital care and other public health care services, thereby sharing the financial risk associated with growth in demand and providing strong incentives for efficient care. (The assumption of greater funding responsibility by the Commonwealth Government would be met through commensurate reductions in Commonwealth grants or other funding to state governments.)

Under the new funding arrangements, the Commonwealth Government would pay:

- 100 per cent of the efficient cost of public hospital outpatient services with an agreed, capped activity-based budget; and
- 40 per cent of the efficient cost of every public patient admission to a hospital, sub-acute or mental health care facility and every attendance at a public hospital emergency department.

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.

'Medicare Select'

While we agree that there will be significant benefits of transparency, accountability and efficiency under the Healthy Australia Accord – and its implementation should commence now – we also believe there is a real need to further improve the responsiveness and efficiency of the health system and its capacity for innovation. We agree that greater consumer choice and provider competition and better use of public and private health resources have the potential to achieve this through the development of **a uniquely Australian governance model for health care that builds on and expands Medicare**. The new model we are proposing is based on the establishment of 'health and hospital plans'. We have given this new governance model the working title 'Medicare Select'.

In brief, under '**Medicare Select**', the Commonwealth Government would be the sole government funder of health services. All Australians would automatically belong to a government operated **health and hospital plan**, which could be a national plan or a plan operated by a state government. People could readily select to move to another health and hospital plan, which could be another government

operated plan, or a plan operated by a not-for-profit or private enterprise. Similar to Medicare now, health and hospital plans would cover a mandatory set of health services made explicit in a **universal service obligation**, which would include hospital and medical care and pharmaceuticals.

Health and hospital plans would receive funds from the Commonwealth Government on a risk-adjusted basis for each person. Through contracting arrangements with public and private providers, plans would purchase services to meet the full health care needs of their members. This would entail a **strategic approach to innovative purchasing**, focusing on people's health needs over time, and across service settings, rather than on the purchase of individual elements of the service.

While agreeing that 'Medicare Select' offers a number of potential advantages, we recognise that there are many technical and policy challenges in developing and implementing such an approach, and a number of design choices about how health and hospital plans might work that we have not been able to fully address. We therefore recommend that, over the next two years, the Commonwealth Government commits to **exploring the design, benefits, risks, and feasibility around the potential implementation of 'Medicare Select'**.

Implementing and funding reform

Roadmap for reform

To give impetus to action, we have included a **roadmap for reform** in our report, identifying who should be responsible for reforms, which reforms require changes to government responsibilities and/or federal funding arrangements, and where legislative change may be required.

The **first step to give effect to a national health system** should be for the Council of Australian Governments (COAG) to agree in 2009 to develop the new Healthy Australia Accord. The aim should be to **agree the Healthy Australia Accord in 2010**. To accelerate the pace of reform, one option would be for the Accord to be a high level agreement, supported by more detailed individual agreements on specific reform elements. This would allow early action on some reforms while others are still being developed.

Financial implications

We have also included a summary of the **financial implications** of our reform plan. As an indicative estimate, the full year annual recurrent costs of implementing our reforms to Australia's health system are between \$2.8 billion and \$5.7 billion. In addition, an investment in capital over five years of between \$4.3 billion and \$7.3 billion would be required to transform the system's infrastructure to enable our reforms. We note that changes to the actual level of expenditure in any one year will depend on the pace of the implementation of the reforms. If phased in over several years, as we anticipate, the impact on expenditure in any one year could be quite modest.

These estimates include indicative costs for improved public dental care, but not for the 'Denticare Australia' scheme. We consider the 'Denticare Australia' scheme separately. Once fully implemented, 'Denticare Australia' would transfer to the Commonwealth Government responsibility for funding of \$3.6 billion per year, which is currently spent privately through private health insurance or directly by consumers. We have suggested this could be offset by an increase in the Medicare levy of about 0.75 per cent of taxable income.

The estimates of recurrent and capital costs focus just on the costs of implementing the reforms. They do not take full account of the impact on health expenditure of the improvements in performance and efficiency that will be achieved in the medium to longer term through better provision of more appropriate health services as a result of the reforms.

To do this, we commissioned the Australian Institute of Health and Welfare (AIHW) to estimate the impacts of our key recommended reforms on health expenditure over the medium to long term. Overall, the AIHW's analysis indicates that the net effect of our reforms would be to reduce the burden of disease and deliver a better mix of more accessible and effective services at a lower cost and higher productivity, resulting in **lower projected costs overall in the medium to longer term.**

According to the AIHW, compared with current projections of health and residential aged care expenditure, our key reforms will save \$4 billion a year by 2032-33. Projected health and residential aged care expenditure as a proportion of GDP will grow to 12.2 per cent of GDP in 2032-33, which is less than the current projection of 12.4 per cent. In other words, **investing in these reforms now will deliver greater value for the community in the future.**

Some may query the wisdom of undertaking significant reform of health care, and incurring increased expenditure, at a time when Australia's economy and government outlays are under pressure from a global financial downturn.

But a healthy population and an efficient and effective health care system are essential to maximising the wellbeing of our nation, and the productivity of our economy and workforce. Our recommendations for reform are aimed at achieving an improved distribution of resources to provide more efficient and effective health care over the next five to ten years. Improving the performance of a sector that represents a tenth of our economy – and which is expected to grow to become an eighth of our economy in the next twenty years – is essential to proper economic management.

Furthermore, we believe that there would also be a cost in not pursuing our recommendations – a cost in terms of the forgone improvements in health status and in equity of health outcomes, and of a less efficient, less responsive health care system that is also less well prepared for the challenges of the future.

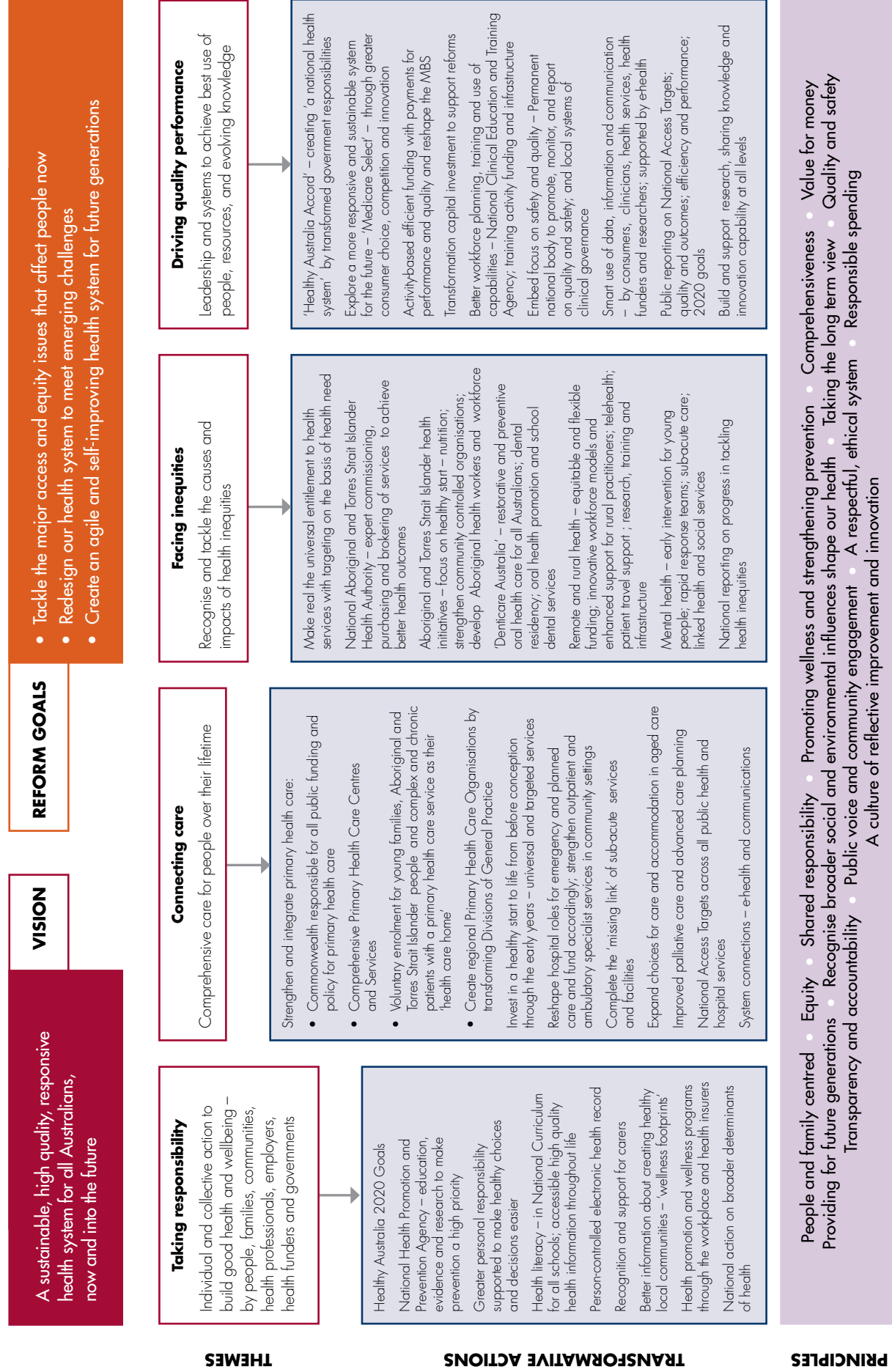
Embracing reform

This final report of the National Health and Hospitals Reform Commission is the culmination of 16 months of discussion, debate, consultation, research and deliberation. From our experience we are certain that there is a genuine desire for reform of Australia's health system. Our existence as a Commission, and the endorsement of our terms of reference by all governments, demonstrates governments' acceptance that improvements to Australia's health system are needed. Moreover, based on our consultations both in meetings and through the submissions we have received, we know the community, health professionals and health services are also ready to embrace reform.

We urge governments to continue consultation and engagement with the community, health professionals and health services. The success of the reform agenda will depend upon it. Change is more readily achieved, and with best results, when it is informed and owned by all of us.

The next page provides an overview 'map' of our national plan for health reform. It links the recommended actions to our reform goals, and ultimately to our vision for a sustainable, high quality, responsive health system for all Australians, now and into the future.

A Healthier Future For All Australians



RECOMMENDATIONS



RECOMMENDATIONS

Taking Responsibility

*Individual and collective action to build good health and wellbeing –
by people, families, communities, health professionals, employers,
health funders and governments*

Building good health and wellbeing into our communities and our lives

1. We affirm the value of universal entitlement to medical, pharmaceutical and public hospital services under Medicare which, together with choice and access through private health insurance, provides a robust framework for the Australian health care system. To promote greater equity, universal entitlement needs to be overlaid with targeting of health services to ensure that disadvantaged groups have the best opportunity for improved health outcomes.
2. Australian governments and the Australian community should acknowledge that the scope of the universal entitlement and service obligation funded by public monies will need to be debated over time to ensure that it is realistic, affordable, fair, and will deliver the best health outcomes, while reflecting the values and priorities of the community. Mechanisms for effectively conducting this dialogue should be developed and should include expert clinical, economic and consumer perspectives.
3. Listening to the views of all Australians about our health system and health reform is essential to the ongoing sustainability and responsiveness of our health system. Accordingly, we recommend regular monitoring and public reporting of community confidence in the health system and the satisfaction of our health workforce.
4. We recommend that public reporting on health status, health service use, and health outcomes by governments, private health insurers and individual health service providers identifies the impact on population groups who are likely to be disadvantaged in our communities.
5. We recommend the preparation of a regular report that tracks our progress as a nation in tackling health inequity.
6. We recommend the development of accessible information on the health of local communities. This information should take a broad view of the factors contributing to healthy communities, including the 'wellness footprint' of communities and issues such as urban planning, public transport, community connectedness, and a sustainable environment.
7. We support the delivery of wellness and health promotion programs by employers and private health insurers. Any existing regulatory barriers to increasing the uptake of such programs should be reviewed.
8. We recommend that governments commit to establishing a rolling series of ten-year goals for health promotion and prevention, to be known as Healthy Australia Goals, commencing with Healthy Australia 2020 Goals. The goals should be developed to ensure broad community ownership and commitment, with regular reporting by the National Health Promotion and Prevention Agency on progress towards achieving better health outcomes under the ten-year goals.
9. We recommend the establishment of an independent National Health Promotion and Prevention Agency. This agency would be responsible for national leadership on the Healthy Australia 2020 goals, as well as building the evidence base, capacity and infrastructure that is required so that prevention becomes the platform of healthy communities and is integrated into all aspects of our health care system.

We recommend that the National Health Promotion and Prevention Agency (NHP&PA) would also collate and disseminate information about the efficacy and cost effectiveness of health promotion including primary, secondary and tertiary prevention interventions and relevant population and public health activities.

10. We support strategies that help people take greater personal responsibility for improving their health through policies that 'make healthy choices easy choices'. This includes individual and collective action to improve health by people, families, communities, health professionals, health insurers, employers and governments. Further investigation and development of such strategies should form part of NHP&PA work on the Healthy Australia 2020 Goals, targeting cross portfolio and cross industry action.
11. We recommend that health literacy is included as a core element of the National Curriculum and that it is incorporated in national skills assessment. This should apply across primary and secondary schools.
12. We urge all relevant groups (including health services, health professionals, non-government organisations, media, private health insurers, food manufacturers and retailers, employers and governments) to provide access to evidence-based, consumer-friendly information that supports people in making healthy choices and in better understanding and making decisions about their use of health services.
13. To support people's decision making and management of their own health we recommend that, by 2012, every Australian should be able to have a personal electronic health record that will at all times be owned and controlled by that person.
14. We acknowledge the vital role of informal/family carers in supporting and caring for people with chronic conditions, mental disorders, disabilities and frailty. We recommend that carers be supported through educational programs, information, mentoring, timely advice and, subject to the consent of those they care for, suitable engagement in health decisions and communications. We also recommend improved access to respite care arrangements to assist carers sustain their role over time and that the health of carers should also be a priority of primary health care services dealing with people with chronic conditions.
15. We recognise that the health of individuals and the community as a whole is determined by many factors beyond health care, such as a person's social circumstances and the physical environment in which they live; how they live their lives – their behaviours and lifestyles; and their biological and genetic predispositions. We commend the World Health Organisation's call for action by national governments to address the social determinants of health.

Connecting Care

Comprehensive care for people over their lifetime

Creating strong primary health care services for everyone

16. We recommend that, to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding.
17. We recommend that, in its expanded role, the Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres and Services. We suggest this could be achieved through a range of mechanisms including initial fixed establishment grants on a competitive and targeted basis. By 2015, we should have a comprehensive primary health care system that is underpinned by a national policy and funding framework with services evolving in parallel.

18. We recommend that young families, Aboriginal and Torres Strait Islander people, and people with chronic and complex conditions (including people with a disability or a long-term mental illness) have the option of enrolling with a single primary health care service to strengthen the continuity, coordination and range of multidisciplinary care available to meet their health needs and deliver optimal outcomes. This would be the enrolled family or patient's principal 'health care home'. To support this, we propose that
 - there will be grant funding to support multidisciplinary services and care coordination for that service tied to levels of enrolment of young families and people with chronic and complex conditions;
 - there will be payments to reward good performance in outcomes, including quality and timeliness of care, for the enrolled population; and
 - over the longer term, payments will be developed that bundle the cost of packages of primary health care over a course of care or period of time, supplementing fee-based payments for episodic care.
19. We recommend embedding a strong focus on quality and health outcomes across all primary health care services. This requires the development of sound patient outcomes data for primary health care. We also want to see the development of performance payments for prevention, timeliness and quality care.
20. We recommend improving the way in which general practitioners, primary health care professionals, and medical and other specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting. These arrangements should promote good communication and the vital role of primary health care professionals in the ongoing management and support of people with chronic and complex conditions in partnership with specialist medical consultants and teams who provide assessment, complex care planning and advice.
21. Service coordination and population health planning priorities should be enhanced at the local level through the establishment of Primary Health Care Organisations, evolving from or replacing the existing Divisions of General Practice. These organisations will need to:
 - have appropriate governance to reflect the diversity of clinicians and services forming comprehensive primary health care;
 - be of an appropriate size to provide efficient and effective coordination (say, approximately 250,000 to 500,000 population depending on health need, geography and natural catchment); and
 - meet required criteria and goals to receive ongoing Commonwealth funding support.

Nurturing a healthy start

22. We recommend an integrated strategy for the health system to nurture a healthy start to life for Australian children. The strategy has a focus on health promotion and prevention, early detection and intervention and management of risk, better access to primary health care, and better access to and coordination of health and other services for children with chronic or severe health or developmental concerns.

We recommend a strategy for a healthy start based on three building blocks:

- most importantly, a partnership with parents, supporting families – and extended families – in enhancing children's health and wellbeing;
- a life course approach to understanding health needs at different stages of life, beginning with pre-conception, and covering the antenatal and early childhood period up to eight years of age. While the research shows that the first three years of life are particularly important for early development, we also note the importance of the period of the transition to primary school; and

- a child and family-centred approach to shape the provision of health services around the health needs of children and their families. Under a 'progressive universalism' approach, there would be three levels of care: universal, targeted, and intensive care.
23. We recommend beginning the strategy for nurturing a healthy start to life before conception. Universal services would focus on effective health promotion to encourage good nutrition and healthy lifestyles, and on sexual and reproductive health services for young people. Targeted services would include ways to help teenage girls at risk of pregnancy. In the antenatal period, in addition to good universal primary health care, we recommend targeted care for women with special needs or at risk, such as home visits for very young, first-time mothers.
 24. We recommend that universal child and family health services provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring (with contacts weighted towards the first three years of life), including:
 - the initial contact would be universally offered as a home visit within the first two weeks following the birth. The schedule would include the core services of monitoring of child health, development and wellbeing; early identification of family risk and need; responding to identified needs; health promotion and disease prevention (for example, support for breastfeeding); and support for parenting;
 - where the universal child and family health services identify a health or developmental issue or support need, the service will provide or identify a pathway for targeted care, such as an enhanced schedule of contacts and referral to allied health and specialist services; and
 - where a child requires more intensive care for a disability or developmental concerns, a care coordinator, associated with a primary health care service, would be available to coordinate the range of services these families often need.
 25. We recommend that all primary schools have access to a child and family health nurse for promoting and monitoring children's health, development and wellbeing, particularly through the important transition to primary school.
 26. We recommend that responsibility for nurturing a healthy start to life be embedded in primary health care to ensure a comprehensive understanding of a child's health needs and continuity of care. Families would have the opportunity to be enrolled with a primary health care service as this would enable well integrated and coordinated care and a comprehensive understanding of the health needs of children and their families.

Ensuring timely access and safe care in hospitals

27. We recommend development and adoption of National Access Targets for timeliness of care. For example:
 - a national access target for people requiring an acute mental health intervention (measured in hours);
 - a national access target for patients requiring urgent primary health care (measured in hours or days);
 - national access targets for people attending emergency departments (measured in minutes to hours);
 - a national access target for patients requiring coronary artery surgery or cancer treatment (measured in weeks/days); and
 - a national access target for patients requiring other planned surgery or procedures (measured in months).

These National Access Targets should be developed incorporating clinical, economic and community perspectives through vehicles like citizen juries and may evolve into National Access Guarantees subject to ensuring there is no distortion in allocation of health resources.

28. A share of the funding potentially available to health services should be linked to meeting (or improving performance towards) the access targets, payable as a bonus.
29. We recommend there be financial incentives to reward good performance in outcomes and timeliness of care. One element of this should be for timely provision of suitable clinical information (such as discharge information) including details of any follow-up care required.
30. We recommend the use of activity-based funding for both public and private hospitals using casemix classifications (including the cost of capital), which means:
 - this approach should be used for inpatient and outpatient treatment;
 - emergency department services should be funded through a combination of fixed grants (to fund availability) and activity-based funding; and
 - for hospitals with a major emergency department service the costs of maintaining bed availability to admit people promptly should be recognised in the funding arrangements.
31. We recommend that all hospitals review provision of ambulatory services (outpatients) to ensure they are designed around patients' needs and, where possible, located in community settings.
32. To support quality improvement, we recommend that data on safety and quality should be collated, compared and provided back to hospitals, clinical units and clinicians in a timely fashion to expedite quality and quality improvement cycles. Hospitals should also be required to report on their strategies to improve safety and quality of care and actions taken in response to identified safety issues.
33. To improve accountability, we recommend that public and private hospitals be required to report publicly on performance against a national set of indicators which measure access, efficiency and quality of care provided.
34. To better understand people's use of health services and health outcomes across different care settings, we recommend that public and private hospital episode data should be collected nationally and linked to MBS and PBS data using a patient's Medicare card number.
35. We recommend that the future planning of hospitals should encourage greater delineation of hospital roles including separation of planned and emergency treatment, and optimise the provision and use of public and private hospital services.
36. We recommend a nationally led, systemic approach to encouraging, supporting and harnessing clinical leadership within hospitals and broader health settings and across professional disciplines.

Restoring people to better health and independent living

37. The visibility of, and access to, sub-acute care services must be increased for people to have the best opportunity to recover from injury or illness and to be restored to independent living. To do this, we recommend:
 - funding must be more directly linked to the delivery and growth of sub-acute services;
 - a priority focus should be the development of activity-based funding models for sub-acute services (including the cost of capital), supported by improvements in national data and definitions for sub-acute services; and
 - the use of activity-based funding complemented by incentive payments related to improving outcomes for patients.
38. We recommend that clear targets to increase provision of sub-acute services be introduced by June 2010. These targets should cover both inpatient and community-based services and should link the demand for sub-acute services to the expected flow of patients from acute services and

other settings. Incentive funding under the National Partnership Payments could be used to drive this expansion in sub-acute services.

39. We recommend that investment in sub-acute services infrastructure be one of the top priorities for the Health and Hospitals Infrastructure Fund.
40. We recommend planning and action to ensure that we have the right workforce available and trained to deliver the growing demand for sub-acute services, including in the community. Accordingly, we support the need for better data on the size, skill mix and distribution of this workforce, including rehabilitation medicine specialists, geriatricians and allied health staff.
41. We recognise the vital role of equipment, aids and other devices in helping people to improve health functioning and to live as independently as possible in the community. We recommend affordable access to such equipment should be considered under reforms to integrated safety net arrangements.

Increasing choice in aged care

42. We recommend that government subsidies for aged care should be more directly linked to people rather than places. As a better reflection of population need, we recommend the planning ratio transition from the current basis of places per 1000 people aged 70 or over to care recipients per 1000 people aged 85 or over.
43. We recommend that consideration be given to permitting accommodation bonds or alternative approaches as options for payment for accommodation for people entering high care, provided that removing the regulated limits on the number of places has resulted in sufficient increased competition in supply and price.
44. We recommend requiring aged care providers to make standardised information on service quality and quality of life publicly available on **agedcareaustralia.gov.au**, to enable older people and their families to compare aged care providers.
45. We recommend consolidating aged care under the Commonwealth Government by making aged care under the Home and Community Care (HACC) program a direct Commonwealth program.
46. We recommend development and introduction of streamlined, consistent assessment for eligibility for care across all aged care programs. This should include:
 - transferring the Aged Care Assessment Teams to Commonwealth Government responsibility;
 - developing new assessment tools for assessing people's care needs; and
 - integrating assessment for Home and Community Care Services with more rigorous assessment for higher levels of community and residential care.
47. We recommend that there be a more flexible range of care subsidies for people receiving community care packages, determined in a way that is compatible with care subsidies for residential care.
48. We recommend that people who can contribute to the costs of their own care should contribute the same for care in the community as they would for residential care (not including accommodation costs).
49. We recommend that people supported to receive care in the community should be given the option to determine how the resources allocated for their care and support are used.
50. We recommend that once assessment processes, care subsidies and user payments are aligned across community care packages and residential care, older people should be given greater scope to choose for themselves between using their care subsidy for community or for residential care.

Notwithstanding this, we note that, given the increase in frailty and complexity of care needs, for many elderly people residential care will remain the best and only viable option for meeting their care needs. The level of care subsidies should be periodically reviewed to ensure they are adequate to meet the care needs of the most frail in residential settings.

In the lead up to freeing up choice of care setting, there should be a phased plan over five years to enable aged care providers to convert existing low care residential places to community places.

51. We recommend that all aged care providers (community and residential) should be required to have staff trained in supporting care recipients to complete advance care plans for those who wish to do so.
52. We recommend that funding be provided for use by residential aged care providers to make arrangements with primary health care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes.
53. The safety, efficiency and effectiveness of care for older people in residential and community settings can be assisted by better and innovative use of technology and communication. We recommend:
 - supporting older people, and their carers, with the person's consent, to activate and access their own person-controlled electronic health record;
 - improved access to e-health, online and telephonic health advice for older people and their carers and home and personal security technology;
 - increased use of electronic clinical records and e-health enablers in aged care homes, including capacity for electronic prescribing by attending medical and other credentialled practitioners, and providing a financial incentive for electronic transfer of clinical data between services and settings (general practitioners, hospital and aged care), subject to patient consent; and
 - the hospital discharge referral incentive scheme must include timely provision of pertinent information on a person's hospital care to the clinical staff of their aged care provider, subject to patient consent.

Caring for people at the end of life

54. We recommend building the capacity and competence of primary health care services, including Comprehensive Primary Health Care Centres and Services, to provide generalist palliative care support for their dying patients. This will require greater educational support and improved collaboration and networking with specialist palliative care service providers.
55. We recommend strengthening access to specialist palliative care services for all relevant patients across a range of settings, with a special emphasis on people living in residential aged care facilities.
56. We recommend that additional investment in specialist palliative care services be directed to support more availability of these services to people at home in the community.
57. We recommend that advance care planning be funded and implemented nationally, commencing with all residential aged care services, and then being extended to other relevant groups in the population. This will require a national approach to education and training of health professionals including greater awareness and education among health professionals of the common law right of people to make decisions on their medical treatment, and their right to decline treatment. We note that, in some states and territories, this is complemented by supporting legislation that relates more specifically to end of life and advance care planning decisions.

Facing Inequities

Recognise and tackle the causes and impacts of health inequities

Closing the health gap for Aboriginal and Torres Strait Islander peoples

58. We recommend that the Commonwealth Department of Health and Ageing take a lead in the inter-sectoral collaboration that will be required at the national level to redress the impacts of the social determinants of health to close the gap for Aboriginal and Torres Strait Islander peoples.
59. We recommend an investment strategy for Aboriginal and Torres Strait Islander people's health that is proportionate to health need, the cost of service delivery, and the achievement of desired outcomes. This requires a substantial increase on current expenditure.
60. We recommend strengthening and expanding organisational capacity and sustainability of Community Controlled Health Services to provide and broker comprehensive primary health care services. We recommend this should occur within OATSIH or a similar group within the Commonwealth Department of Health and Ageing, but should be separate to the purchasing function.
61. Acknowledging that significant additional funding in Aboriginal and Torres Strait Islander health care will be required to close the gap, we recommend that a dedicated, expert commissioning group be established to lead this investment. This could be achieved by the establishment of a National Aboriginal and Torres Strait Islander Health Authority within the Health portfolio to commission and broker services specifically for Aboriginal and Torres Strait Islander people and their families as a mechanism to focus on health outcomes and ensure high quality and timely access to culturally appropriate care.
62. We recommend that accreditation processes for health services and education providers incorporate, as core, specific Indigenous modules to ensure quality clinical and culturally appropriate services.
63. We recommend additional investment includes the funding of strategies to build an Aboriginal and Torres Strait Islander health workforce across all disciplines and the development of a workforce for Aboriginal and Torres Strait Islander health.
64. Good nutrition and a healthy diet are key elements of a healthy start to life. But many Aboriginal and Torres Strait Islander people living in remote areas have limited access to affordable healthy foods. We recommend an integrated package to improve the affordability of fresh food – particularly fruit and vegetables – in these targeted remote communities. This package would include subsidies to bring the price of fresh food in line with large urban and regional centres, investment in nutrition education and community projects, and food and nutrient supplementation for schoolchildren, infants, and pregnant and breastfeeding women. The strategy would be developed in consultation with these Aboriginal and Torres Strait Islander communities, building on some of the successful work already underway. There would be an evaluation to assess the benefits of extending the program to other communities, focusing on the changes to eating habits and improvements to health.

Delivering better health outcomes for remote and rural communities

65. Flexible funding arrangements are required to reconfigure health service delivery to achieve the best outcomes for the community. To facilitate locally designed and flexible models of care in remote and small rural communities, we recommend:
 - funding equivalent to national average medical benefits and primary health care service funding, appropriately adjusted for remoteness and health status, be made available for local service provision where populations are otherwise under-served; and

- expansion of the multi-purpose service model to towns with catchment populations of approximately 12,000.
66. Care for people in remote and rural locations necessarily involves bringing care to the person or the person to the care. To achieve this, we recommend:
- networks of primary health care services, including Aboriginal and Torres Strait Islander Community Controlled Services, within naturally defined regions;
 - expansion of specialist outreach services – for example, medical specialists, midwives, allied health, pharmacy and dental/oral health services;
 - telehealth services including practitioner-to-practitioner consultations, practitioner-to-specialist consultations, teleradiology and other specialties and services;
 - referral and advice networks for remote and rural practitioners that support and improve the quality of care, such as maternity care, chronic and complex disease care planning and review, chronic wound management, and palliative care; and
 - ‘on-call’ 24-hour telephone and internet consultations and advice, and retrieval services for urgent consultations staffed by remote medical practitioners.
- Further, we recommend that funding mechanisms be developed to support all these elements.
67. We recommend that a patient travel and accommodation assistance scheme be funded at a level that takes better account of the out-of-pocket costs of patients and their families and facilitates timely treatment and care.
68. We recommend that a higher proportion of new health professional educational undergraduate and postgraduate places across all disciplines be allocated to remote and rural regional centres, where possible in a multidisciplinary facility built on models such as clinical schools or university departments of Rural Health.
69. We recommend building health service, clinical and workforce capability through a remote and rural health research program.
70. We recommend that the Clinical Education and Training Agency take the lead in developing:
- an integrated package of strategies to improve the distribution of the health workforce. This package could include strategies such as providing university fee relief, periodic study leave, locum support, expansion of medical bonded scholarships and extension of the model to all health professions; and
 - preferential access for remote and rural practitioners to training provided by specialty colleges recognising related prior learning and clinical experience and/or work opportunities for practitioners returning to the city, and support for those who plan to return again to remote or rural practice once specialty attained.

Supporting people living with mental illness

71. We recommend that a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service.
72. We recommend that the Early Psychosis Prevention and Intervention Centre model be implemented nationally so that early intervention in psychosis becomes the norm.

73. We recommend that every acute mental health service have a rapid-response outreach team for those individuals experiencing psychosis, and subsequently have the acute service capacity to provide appropriate treatment.
74. We recommend that every hospital-based mental health service should be linked with a multi-disciplinary community-based sub-acute service that supports 'stepped' prevention and recovery care.
75. We strongly support greater investment in mental health competency training for the primary health care workforce, both undergraduate and postgraduate, and that this training be formally assessed as part of curricula accreditation processes.
76. We recommend that each state and territory government provide those suffering from severe mental illness with stable housing that is linked to support services.
77. We want governments to increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support.
78. As a matter of some urgency, governments must collaborate to develop a strategy for ensuring that older Australians, including those residing in aged care facilities, have adequate access to specialty mental health and dementia care services.
79. We recommend that state and territory governments recognise the compulsory treatment orders of other Australian jurisdictions.
80. We recommend that health professionals should take all reasonable steps in the interests of patient recovery and public safety to ensure that when a person is discharged from a mental health service that:
 - there is clarity as to where the person will be discharged; and
 - someone appropriate at that location is informed.
81. We recommend a sustained national community awareness campaign to increase mental health literacy and reduce the stigma attached to mental illness.
82. We acknowledge the important role of carers in supporting people living with mental disorders. We recommend that there must be more effective mechanisms for consumer and carer participation and feedback to shape programs and service delivery.

Improving oral health and access to dental care

83. We recommend that all Australians should have universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay. This should occur through the establishment of the 'Denticare Australia' scheme. Under the 'Denticare Australia' scheme, people will be able to select between private or public dental health plans. 'Denticare Australia' would meet the costs in both cases. The additional costs of Denticare could be funded by an increase in the Medicare Levy of 0.75 per cent of taxable income.
84. We recommend the introduction of a one-year internship scheme prior to full registration, so that clinical preparation of oral health practitioners (dentists, dental therapists and dental hygienists) operates under a similar model to medical practitioners. We recognise that this will require an investment in training and capital infrastructure.
85. We recommend the national expansion of the pre-school and school dental programs.
86. We recommend that additional funding be made available for improved oral health promotion, with interventions to be decided based upon relative cost-effectiveness assessment.

Driving Quality Performance

Leadership and systems to achieve best use of people, resources and evolving knowledge

Strengthening the governance of health and health care

87. To give effect to a national health system, we recommend that First Ministers agree to a new Healthy Australia Accord that will clearly articulate the agreed and complementary roles and responsibilities of all governments in improving health services and outcomes for the Australian population.
88. The Healthy Australia Accord would incorporate the following substantial structural reforms to the governance of the health system:
 - 88.1 The Commonwealth Government would assume full responsibility for the policy and public funding of primary health care services. This includes all existing community health, public dental services, family and child health services, and alcohol and drug treatment services that are currently funded by state, territory and local governments.
 - 88.2 The Commonwealth and state and territory governments would move to new transparent and more equitable funding arrangements for public hospitals and public health care services as follows:
 - The Commonwealth Government would meet 100 per cent of the efficient costs of public hospital outpatient services using an agreed casemix classification and an agreed, capped activity-based budget;
 - The Commonwealth Government would pay 40 per cent of the efficient cost of care for every episode of acute care and sub-acute care for public patients admitted to a hospital or public health care facility for care, and for every attendance at a public hospital emergency department; and
 - 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 is effective and efficient.
 - 88.3 The Commonwealth Government would 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.
 - 88.4 The Commonwealth Government would assume full responsibility for the purchasing of all health services for Aboriginal and Torres Strait Islander people through the establishment of a National Aboriginal and Torres Strait Islander Health Authority. This would include services that are provided through mainstream and Community Controlled Health Services, including services that are currently funded by state, territory and local governments.
 - 88.5 The Commonwealth Government would assume full responsibility for providing universal access to dental care (preventive, restorative and dentures). This would occur through the establishment of the 'Denticare Australia' scheme.

- 88.6 The Commonwealth Government would assume full responsibility for public funding of aged care. This would include the Home and Community Care Program for older people and aged care assessment.
- 88.7 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.
- 88.8 These changes to roles and responsibilities allow for the continued involvement of states, territories and local governments in providing health services.
- 88.9 The Commonwealth, state and territory governments would agree to establish national approaches to health workforce planning and education, professional registration, patient safety and quality (including service accreditation), e-health, performance reporting (including the provision of publicly available data on the performance of all aspects of the health system), prevention and health promotion, private hospital regulation, and health intervention and technology assessment.
89. We believe that there is a real need to further improve the responsiveness and efficiency of the health system and capacity for innovation. We agree that greater consumer choice and provider competition and better use of public and private health resources could offer the potential to achieve this through the development of a uniquely Australian governance model for health care that builds on and expands Medicare. This new model is based on the establishment of health and hospital plans, and draws upon features of social health insurance as well as encompassing ideas of consumer choice, provider competition and strategic purchasing. We have given this new governance model the working title, 'Medicare Select'.
90. We recommend that the Commonwealth Government commits to explore the design, benefits, risks and feasibility around the potential implementation of health and hospital plans to the governance of the Australian health system. This would include examination of the following issues:
- 90.1 The basis for determination of the universal service entitlement to be provided by health and hospital plans (including the relationship between the Commonwealth Government and health and hospital plans with regard to growth in the scope, volume, and costs of core services, the process for varying the level of public funding provided to the health and hospital plans for purchasing of core services; and the nature of any supplementary benefits that might be offered by plans);
- 90.2 The scope, magnitude, feasibility and timing of financial transfers between state, territory and local governments and the Commonwealth Government in order to achieve a single national pool of public funding to be used as the basis for funding health and hospital plans;
- 90.3 The basis for raising financing for health and hospital plans (including the extent to which transparency should be promoted through use of a dedicated levy or through publicly identifying the share of consolidated revenue that makes up the universal service entitlement);
- 90.4 The potential impact on the use of public and private health services including existing state and territory government funded public hospitals and other health services (incorporating consideration of whether regulatory frameworks for health and hospital plans should influence how plans purchase from public and private health services including whether there should be a requirement to purchase at a default level from all hospitals and primary health care services);
- 90.5 The approach to ensuring an appropriate level of investment in capital infrastructure in public and private health services (including different approaches to the financing of capital across public and private health services and the treatment of capital in areas of market failure);

- 90.6 The relationship between the health and hospital plans and the continued operation of the Medicare and Pharmaceutical Benefits Schemes (including whether there should continue to be national evaluation, payment and pricing arrangements and identifying what flexibility in purchasing could be delegated to health and hospital plans concerning the coverage, volume, price, and other parameters in their purchasing of medical and pharmaceutical services in hospitals and the community);
- 90.7 The potential role of private health insurance alongside health and hospital plans (including defining how private health insurance would complement health and hospital plans, the potential impact on membership, premiums, insurance products and the viability of existing private health insurance; and any changes to the Commonwealth Government's regulatory, policy or financial support for private health insurance);
- 90.8 The potential roles of state, territory and local governments under health and hospital plans (including issues related to the handling of functions such as operation of health services, employment of staff, industrial relations and the implications for transmission of business and any required assumption of legislative responsibility by the Commonwealth Government related to these changed functions, together with the operation by state and territory governments of health and hospital plans);
- 90.9 The range of responsibilities and functions to be retained or assumed by Australian governments (and not delegated to health and hospital plans) in order to ensure national consistency or to protect 'public good' functions (including, as potential examples, functions such as health workforce education and training, research, population and public health and bio security);
- 90.10 The approach to ensuring equitable access to health services in areas of market failure including in remote and rural areas of Australia (including the relevant roles of health and hospital plans in regard to the development and capacity building of a balanced supply and distribution of health services, and the approach by plans to regional and local consultation and engagement on population needs);
- 90.11 The necessary regulatory framework to support the establishment and operation of health and hospital plans (including issues relating to entry and exit of plans, minimum standards for the establishment of plans, any requirements relating to whether plans are able to also provide health services, and the potential separation of health and hospital plans and existing private health insurance products);
- 90.12 The development of appropriate risk-adjustment mechanisms to protect public funding and consumers (including potential mechanisms such as the use of risk-adjusted payments by the Commonwealth Government to health and hospital plans, reinsurance arrangements and risk-sharing arrangements related to scope, volume and cost of services covered under health and hospital plans);
- 90.13 The necessary regulatory framework to protect consumers (including potential requirements around guaranteed access, portability, co-payments, information provision on any choices or restrictions relating to eligible services and health professionals/health services covered under individual health and hospital plans, and measures to regulate anti-competitive behaviours and complaints mechanisms).

Raising and spending money for health services

91. Health and aged care spending is forecast to rise to 12.4 per cent of gross domestic product in 2032–33. We believe that:
- major reforms are needed to improve the outcomes from this spending and national productivity and to contain the upward pressure on health care costs; and
 - improved health outcomes are vital in promoting a healthy economy through greater productivity and higher labour force participation; and

- evidence-based investment in strengthened primary health care services and prevention and health promotion to keep people healthy is required to help to contain future growth in spending.

92. We want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade.
93. We recommend a systematic mechanism to formulating health care priorities that incorporates clinical, economic and community perspectives through vehicles like citizen juries.
94. We recommend a review of the scope and structure of safety net arrangements to cover a broader range of health costs. We want an integrated approach that is simpler and more family-centred to protect families and individuals from unaffordably high out-of-pocket costs of health care.
95. We recommend that incentives for improved outcomes and efficiency should be strengthened in health care funding arrangements.

This will involve a mix of:

- activity-based funding (e.g. fee for service or casemix budgets). This should be the principal mode of funding for hospitals;
- payments for care of people over a course of care or period of time. There should be a greater emphasis on this mode of funding for primary health care; and
- payments to reward good performance in outcomes and timeliness of care. There should be a greater emphasis on this mode of funding across all settings.

We further recommend that these payments should take account of the cost of capital and cover the full range of health care activities including clinical education.

96. We believe that funding arrangements may need to be adjusted to take account of different costs and delivery models in different locations and to encourage service provision in under-served locations and populations.
97. Additional capital investment will be required on a transitional basis to facilitate our recommendations. In particular, we recommend that priority areas for new capital investment should include:
 - the establishment of Comprehensive Primary Health Care Centres and Services;
 - an expansion of sub-acute services including both inpatient and community-based services;
 - investments to support expansion of clinical education across clinical service settings; and
 - targeted investments in public hospitals to support reshaping of roles and functions, clinical process redesign and a reorientation towards community-based care; and
 - capital can be raised through both government and private financing options.

The ongoing cost of capital should be factored into all service payments.

Working for us: a sustainable health workforce for the future

98. We recommend supporting our health workforce by:
 - promoting a culture of mutual respect and patient focus of all health professions through shared values, management structures, compensation arrangements, shared educational experiences, and clinical governance processes that support team approaches to care;
 - supporting effective communication across all parts of the health system;

- investing in management and leadership skills development and maintenance for managers and clinicians at all levels of the system;
- promoting quality and a continuous improvement culture by providing opportunities and encouraging roles in teaching, research, quality improvement processes, and clinical governance for all health professionals across service settings;
- providing timely relevant data on comparative clinical performance and latest practice knowledge to support best practice and continuous quality improvement;
- improving clinical engagement through mechanisms to formally and informally involve all health professionals in guiding the management and future directions of health reform including establishing Clinical Senates at national, regional and local levels, subject-specific taskforces, and conducting health workforce opinion surveys; and
- recognising and supporting the health needs of health workers including setting the benchmark for best practice in workplace health programs.

99. To improve access to care and reflect current and evolving clinical practice, we recommend that:

- Medicare rebates should apply to relevant diagnostic services and specialist medical services ordered or referred by nurse practitioners and other health professionals having regard to defined scopes of practice determined by recognised health professional certification bodies;
- Pharmaceutical Benefits Scheme subsidies (or, where more appropriate, support for access to subsidised pharmaceuticals under section 100 of the National Health Act 1953) should apply to pharmaceuticals prescribed from approved formularies by nurse practitioners and other registered health professionals according to defined scopes of practice;
- where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialled for defined scopes of practice; and
- the Medicare Benefits Schedule should apply to specified activities performed by a nurse practitioner, midwife or other competent health professional, credentialled for defined scopes of practice, and where collaborative team models of care with a general practitioner, specialist or obstetrician are demonstrated.

100. We recommend a new education framework for the education and training of health professionals:

- moving towards a flexible, multi-disciplinary approach to the education and training of all health professionals;
- incorporating an agreed competency-based framework as part of broad teaching and learning curricula for all health professionals;
- establishing a dedicated funding stream for clinical placements for undergraduate and postgraduate students; and
- ensuring clinical training infrastructure across all settings (public and private, hospitals, primary health care and other community settings).

101. To ensure better collaboration, communication and planning between the health services and health education and training sectors, we recommend the establishment of a National Clinical Education and Training Agency:

- to advise on the education and training requirements for each region;
- to assist with planning clinical education infrastructure across all service settings, including rural and remote areas;
- to form partnerships with local universities, vocational education and training organisations, and professional colleges to acquire clinical education placements from health service providers, including a framework for activity-based payments for undergraduates' clinical education and postgraduate training;

- to promote innovation in education and training of the health workforce;
- as a facilitator for the provision of modular competency-based programs to up-skill health professionals (medical, nursing, allied health and Aboriginal health workers) in regional, rural and remote Australia; and
- to report every three years on the appropriateness of accreditation standards in each profession in terms of innovation around meeting the emerging health care needs of the community.

Further, we recommend that the governance, management and operations of the Agency should include a balance of clinical and educational expertise, and public and private health services representation in combination with Commonwealth and state health agencies.

While the Agency has an overarching leadership function, it should support implementation and innovation at the local level.

102. We support national registration to benefit the delivery of health care across Australia.
103. We recommend implementing a comprehensive national strategy to recruit, retain and train Aboriginal and Torres Strait Islander health professionals at the undergraduate and postgraduate level including:
 - setting targets for all education providers, with reward payments for achieving health professional graduations;
 - funding better support for Aboriginal and Torres Strait Islander health students commencing in secondary education; and
 - strengthening accrediting organisations' criteria around cultural safety.

We recommend additional investment includes the funding of strategies to build an Aboriginal and Torres Strait Islander health workforce across all disciplines and the development of a workforce for Aboriginal and Torres Strait Islander health.

104. We recommend that a higher proportion of new health professional educational undergraduate and postgraduate places across all disciplines be allocated to remote and rural regional centres, where possible in a multidisciplinary facility built on models such as clinical schools or university departments of Rural Health.

Fostering continuous learning in our health system

105. To promote research and uptake of research findings in clinical practice, we recommend that clinical and health services research be given higher priority. In particular, we recommend that the Commonwealth increase the availability of part-time clinical research fellowships across all health sectors to ensure protected time for research to contribute to this endeavour.
106. We recommend greater investment in public health, health policy, health services and health system research including ongoing evaluation of health reforms.
107. We further recommend that infrastructure funding (indirect costs) follow direct grants whether in universities, independent research institutes, or health service settings.
108. We believe that the National Health and Medical Research Council should consult widely with consumers, clinicians and health professionals to set priorities for collaborative research centres and supportive grants which:
 - integrate multidisciplinary research across care settings in a 'hub and spoke' model; and
 - have designated resources to regularly disseminate research outcomes to health services.

109. To enhance the spread of innovation across public and private health services, we recommend that:
- the National Institute of Clinical Studies broaden its remit to include a 'clearinghouse' function to collate and disseminate innovation in the delivery of safe and high quality health care;
 - health services and health professionals share best practice lessons by participating in forums such as breakthrough collaboratives, clinical forums, health roundtables, and the like; and
 - a national health care quality innovation awards program is established.
110. To help embed a culture of continuous improvement, we recommend that a standard national curriculum for safety and quality is built into education and training programs as a requirement of course accreditation for all health professionals.
111. The Australian Commission for Safety and Quality in Health Care should be established as a permanent, independent national body. With a mission to measurably improve the safety and quality of health care, the ACS&QHC would be an authoritative knowledge-based organisation responsible for:

Promoting a culture of safety and quality across the system:

- disseminating and promoting innovation, evidence and quality improvement tools;
- recommending national data sets with a focus on the measurement of safety and quality;
- identifying and recommending priorities for research and action;
- advocating for safety and quality; and
- providing advice to governments, bodies (e.g. NHMRC, TGA), clinicians and managers on 'best practice' to drive quality improvement.

Analysing and reporting on safety and quality across all health settings:

- reporting and public commentary on policies, progress and trends in relation to safety and quality;
- developing and conducting national patient experience surveys; and
- reporting on patient reported outcome measures.

Monitoring and assisting in regulation for safety and quality:

- recommending nationally agreed standards for safety and quality, including collection and analysis of data on compliance against these standards. The extent of such regulatory responsibilities requires further consideration of other compliance activities such as accreditation and registration processes.

112. To drive improvement and innovation across all areas of health care, we recommend that a nationally consistent approach is essential to the collection and comparative reporting of indicators which monitor the safety and quality of care delivery across all sectors. This process should incorporate:
- local systems of supportive feedback, including to clinicians, teams and organisations in primary health services and private and public hospitals; and
 - incentive payments that reward safe and timely access, continuity of care (effective planning and communication between providers) and the quantum of improvement (compared to an evidence base, best practice target or measured outcome) to complement activity-based funding of all health services.
113. We also recommend that a national approach is taken to the synthesis and subsequent dissemination of clinical evidence/research, which can be accessed via an electronic portal and adapted locally to expedite the use of evidence, knowledge and guidelines in clinical practice.

114. As part of accreditation requirements, we believe that all hospitals, residential aged care services and Comprehensive Primary Health Care Centres and Services should be required to publicly report on progress with quality improvement and research.

Implementing a national e-health system

115. We recommend that, by 2012, every Australian should be able to:
- have a personal electronic health record that will at all times be owned and controlled by that person;
 - approve designated health care providers and carers to have authorised access to some or all of their personal electronic health record; and
 - choose their personal electronic health record provider.
116. We recommend that the Commonwealth Government legislate to ensure the privacy of a person's electronic health data, while enabling secure access to the data by the person's authorised health providers.
117. We recommend that the Commonwealth Government introduce:
- unique personal identifiers for health care by 1 July 2010; unique health professional identifiers (HPI-I), beginning with all nationally registered health professionals, by 1 July 2010;
 - a system for verifying the authenticity of patients and professionals for this purpose – a national authentication service and directory for health (NASH) – by 1 July 2010; and
 - unique health professional organisation (facility and health service) identifiers (HPI-O) by 1 July 2010.
118. We recommend that the Commonwealth Government develop and implement an appropriate national social marketing strategy to inform consumers and health professionals about the significant benefits and safeguards of the proposed e-health approach.
119. Ensuring access to a national broadband network (or alternative technology, such as satellite) for all Australians, particularly for those living in isolated communities, will be critical to the uptake of person-controlled electronic health records as well as to realise potential access to electronic health information and medical advice.
120. We recommend that the Commonwealth Government mandate that the payment of public and private benefits for all health and aged care services depend upon the ability to accept and provide data to patients, their authorised carers, and their authorised health providers, in a format that can be integrated into a personal electronic health record, such that:
- hospitals must be able to accept and send key data, such as referral and discharge information ('clinical information transfer'), by 1 July 2012;
 - pathology providers and diagnostic imaging providers must be able to provide key data, such as reports of investigations and supplementary information, by 1 July 2012;
 - other health service providers – including general practitioners, medical and non-medical specialists, pharmacists and other health and aged care providers – must be able to transmit key data, such as referral and discharge information ('clinical information transfer'), prescribed and dispensed medications and synopses of diagnosis and treatment, by 1 January 2013; and
 - all health care providers must be able to accept and send data from other health care providers by 2013.

121. We recommend that the Commonwealth Government takes responsibility for, and accelerates the development of a national policy and open technical standards framework for e-health, and that they secure national agreement to this framework for e-health by 2011-12. These standards should include key requirements such as interoperability, compliance and security. The standards should be developed with the participation and commitment of state governments, the IT vendor industry, health professionals, and consumers, and should guide the long-term convergence of local systems into an integrated but evolving national health information system.
122. We recommend that significant funding and resources be made available to extend e-health teaching, training, change management and support to health care practitioners and managers. In addition, initiatives to establish and encourage increased enrolment in nationally recognised tertiary qualifications in health informatics will be critical to successful implementation of the national e-health work program. The commitment to, and adoption of, standards-compliant e-health solutions by health care organisations and providers is key to the emergence of a national health information system and the success of person-controlled electronic health records.
123. With respect to the broader e-health agenda in Australia, we concur with and endorse the directions of the National E-Health Strategy Summary (December 2008), and would add that:
- there is a critical need to strengthen the leadership, governance and level of resources committed by governments to giving effect to the planned National E-Health Action Plan;
 - this Action Plan must include provision of support to public health organisations and incentives to private providers to augment uptake and successful implementation of compliant e-health systems. It should not require government involvement with designing, buying or operating IT systems;
 - in accordance with the outcome of the 2020 Summit and our direction to encourage greater patient involvement in their own health care, that governments collaborate to resource a national health knowledge web portal (comprising e-tools for self-help) for the public as well as for providers. The National Health Call Centre Network (healthdirect) may provide the logical platform for delivery of this initiative; and
 - electronic prescribing and medication management capability should be prioritised and coordinated nationally, perhaps by development of existing applications (such as PBS online), to reduce medication incidents and facilitate consumer amenity.

INTRODUCTION



INTRODUCTION

The Final Report of the National Health and Hospitals Reform Commission presents the why, the what, and the how for a long term reform agenda for Australia's health system.

This Report builds on *Beyond the Blame Game* (April 2008) and our Interim Report (December 2008) to complete a body of work for consideration by governments in their pursuit of health reform.

In April 2009, we released a supplementary paper, *Person-controlled Electronic Health Records*, and a background paper, *The Australian Health Care System: The Potential for Efficiency Gains*, was released in June 2009.

We have actively consulted with governments, government agencies, the health sector, health consumers and with the community through meetings, forums, and our website. Hundreds of submissions have been received in response to our Interim Report.

A Healthier Future For All Australians: Final Report completes a staged process of listening, learning, reviewing and advising that has been extensive, rewarding and, ultimately, a privilege.

Many of the most expert health thinkers in this country and internationally have generously given their time, constructive criticisms and ideas.

And we have been exposed to the very real health needs and concerns of the Australian population put powerfully to us through our community forums, written submissions, and other feedback mechanisms.

We now present our final reform recommendations to the governments of Australia, along with a roadmap for action in the short, medium and long terms.

Health is everybody's business. We all have a role to play in our own health and in the health of our communities. We hope that these recommendations will encourage and inform action by individuals, community and consumer groups, health funds, schools, businesses, universities, professional colleges and industry bodies, clinicians, researchers and health managers to make Australians the healthiest people in the world.

The Work of the NHHRC

Beyond the Blame Game

In our first report, *Beyond the Blame Game* (April 2008), we provided advice to inform the negotiations around the Australian Health Care Agreements.

We identified key health challenges and developed performance indicators and benchmarks that reflected our long-term view of the health system.

We developed a set of design and governance principles to underpin the health system of the future. These principles remain fundamental to our reform agenda and are listed in Appendix F.

Interim Report

In our Interim Report, we proposed reform directions across the broad and complex range of issues facing our health system now and into the future.

These reform directions were grouped under four themes:

- **Taking responsibility** – Individual and collective action to build good health and wellbeing – by people, families, communities, health professionals, employers, health funders and governments;
- **Connecting care** – Comprehensive care for people over their lifetime;
- **Facing inequities** – Recognise and tackle the causes and impacts of health inequities; and
- **Driving quality performance** – Leadership and systems to achieve best use of people, resources, and evolving knowledge.

Following the release of the Interim Report in February 2009, we conducted further consultation. We received more than 280 submissions, conducted an online e-survey and held a series of specific workshops and meetings.

We met with federal, state and territory Health Ministers and Departments.

The generous support and interest of many individuals and groups across the health industry and the community more broadly helped us greatly in this final phase of our work.

A Healthier Future For All Australians: Final Report

Our Final Report builds on the reform directions proposed in our Interim Report to produce a set of 123 recommendations for action.

This report presents the why, the what, and the how for a long term reform agenda for Australia's health system.

In **Chapter 1**, we present a compelling case for long-term reform with action starting now. We explain the problems of today's health system – the difficulties in access, the inequities and gaps in services, quality concerns, and the inefficiencies and waste.

We then turn to the very real challenges ahead of us which we need to prepare for, including the impact of an ageing population on health need and the health workforce; the increasing health burden from chronic diseases, frailty and disability; and the need to keep health care affordable, given consumer expectations, increasing health care costs, and new technology advances.

Finally, we go beyond the horizon to consider the possibilities and the unexpected in a changing world, and why it is important that our health system be able to adapt and continually improve.

In **Chapter 2** we present our vision and reform goals and paint a picture as to how our recommendations fit together to meet issues and challenges in the short, medium and long term.

Chapter 3 presents actions to deal with the major access and equity issues that affect health outcomes for people now.

Chapter 4 describes the transformational changes required to redesign our health system to meet emerging challenges.

Chapter 5 explains what we need to do to create an agile and self-improving health system, which can respond to the changing needs of people in a changing world.

In **Chapter 6**, we show how reforming the governance and structure of the health system will provide the leadership and stewardship our health system needs. We present reforms to achieve 'one national health system' now and ideas on how to further improve the responsiveness, sustainability and capacity for innovation by creating a self-improving health system in the long term.

In **Chapter 7**, we present a roadmap for reform and outline the investment required to implement our recommendations, the gains from this investment in terms of improved health services, and the long-term impact on health expenditure, efficiency and productivity.

CHAPTER 1

A TIME FOR ACTION



1. A time for action

“ We will always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten. Don't let yourself be lulled into inaction.¹ ”

The health of our people is critical to our national economy, our national security and, arguably, our national identity. Health is one of the most important issues for Australians, and it is an issue upon which people often turn to governments for leadership.

Australians have a good health system by most comparisons. Our health outcomes are among the best in the world, we have delivered more successes than most in public health and disease prevention, and we spend less than average on health as a proportion of Gross Domestic Product compared to other Organisation for Economic Co-operation and Development (OECD) countries. We have universal access to medical care, medications and hospitals and an envied mix of public and private financing and provision of care. In comparison with many other countries, we have among the best trained doctors, nurses and other health professionals and a strong international reputation in health and medical research.

While the Australian health system has served us well, it is a system under growing pressure, facing significant emerging challenges as the health needs of our population change. There are already warning signals around the safety of health care, difficulties with access, and frustration over long waiting times. We know that there are unacceptable inequities in health status, a growing awareness of systemic waste and inefficiency, and concern about the affordability of out-of-pocket health costs.

The structure and funding of our health system has become incredibly complex. With so many band aids and ‘work-arounds’, it is not clear who should fix which part, or how one ‘fix’ may affect other parts of the system. What is clear is that providers of health care services are under strain now and will not cope with the rising tide of chronic disease and frailty in the future. We have an overloaded sickness system and offer scant resources for illness prevention and early intervention. Looming shortages in many health professions present an additional threat, particularly when we don’t effectively harness the collective skills and expertise already inherent in our multidisciplinary workforce. Of even greater concern are the rising costs of health care and the growing demands placed upon the system driven by demographic factors and technology. Under these conditions, government’s ability to meet its share of that expenditure is unlikely to be sustainable without reform.

There is a growing disquiet in the Australian community about the viability of our health system, which is reflected in the many Inquiries, Royal Commissions, Taskforces and Reviews. Frequent media stories of personal tragedies and commentary on system failures add fuel to public concerns. People are looking for leadership and effective solutions, now.

This opportunity for major health reform is rare and highly anticipated. There is a unified call for action from the health industry and those it serves to get it right for future generations. These pressures have been recognised by all levels of government and they are listening. We have an extraordinary moment in time in which to redesign our health system for the future with the collaboration of governments, clinical leaders, and the collective goodwill of the people of our nation.

1.1 The critical importance of health

Each of us implicitly values our health and wellbeing. It is often only when we are sick, injured, or the quality of our life is under threat, that we truly recognise its importance as we face up to the potential loss of wellbeing, mobility, or life itself. Many of us make choices about the way we live our lives that potentially damage our bodies or our minds – healthy choices are not always easy choices. For some, the ‘lottery of life’ delivers special challenges to health and wellbeing and living with a disability, chronic disease or disadvantage can be a hard reality.

¹ B Gates (undated), at: <http://www.brainyquote.com/quotes/quotes/b/billgates404193.html>

We often devote more attention to the health and wellbeing of our family, our friends and even distant communities, than to our own health; that is what makes us human – our altruism and fallibility. Few of us can stand by and watch a child die if there is a chance of buying them a few more days or months, no matter the price. As a community, we would find it confronting to be asked to make a decision about rationing high cost health care, such as renal dialysis to the elderly, if it released resources to extend the lives of sick children. The so called ‘rule of rescue’² means that we feel a moral imperative to invest in the care of identifiable individuals, no matter what the economic metrics may show. But the reality is all health care costs money, and money is scarce, facing us all with ‘tragic choices’.³

Health is a major part of our national economy. It generates a significant proportion of economic activity and employs over 7.3 per cent of our working population⁴. Health also underpins our economy. A healthy workforce is a productive workforce; every employer has an interest in keeping their employees safe and well⁵.

It is no wonder, then, that health care consistently rates as one of the most contentious and high profile political issues at election time. While the health system has a vitally important role, broader actions to reduce social risk through improving wealth, education, employment and housing also have a major influence on the status of a society’s health and wellbeing.

Australia may be ‘girt by sea’ but many trends and challenges playing out on the world stage are of significance to us as citizens as well as those responsible for our population’s health and wellbeing. Our world is changing and it affects the way we live our lives, do business, play, communicate, travel and keep healthy.

1.2 Our changing world

Over the last few decades, many of us have been privileged to be observers and participants in history-making changes that have affected the way we live our lives. Australians are not alone in experiencing major social, economic and technological changes which have often left us confused and bemused, mostly better off, but on occasions alarmed.

The world has grown smaller as our populations continue to grow larger. With the means to do so, we can travel almost anywhere and communicate with almost anyone. News and information travels speedily around the globe, and awareness of unfolding dramas and impending crises is shared nation with nation. It is not surprising, then, that many developed nations are experiencing very similar pressures and challenges, at a similar time and in a similar way. The current global financial crisis and the threat of pandemics simply reinforce this notion of ‘one world, one people’.

The health of our populations and the systems of care that have evolved to prevent, diagnose, and treat ill health have long been a shared global concern. Each nation’s health system has evolved, more by chance than design, based on culture, history and politics. All face the common goal of meeting growing health care needs with finite resources. It is true that Australia, along with many developed countries, has made great strides in improving the health of people over the last half century. Compared with 50 years ago, a child born in an OECD country can expect to live nine years longer, infant mortality is five times lower, and the years lost to premature death (before age 70) have been cut in half⁶.

Like many developed countries, Australia has a rapidly ageing population, changing disease patterns, and is experiencing a shift in the size and composition of households. Family structures are changing, in particular patterns of cohabitation, marriage and divorce. In parallel, we have seen massive growth in service industries, and technological innovation has altered the way many of these services are delivered.

2 J. McKie and J. Richardson (2003), ‘The Rule of Rescue’. *Social Science and Medicine*, Vol 56, [12].

3 G Calabresi and P Bobbitt (1978), *Tragic choices: The conflicts society confronts in the allocation of tragically scarce resources*. New York, Norton.

4 Australian Institute of Health and Welfare (2008), *Australia’s health 2008*. Cat. no. AUS 99, (Australian Institute of Health and Welfare: Canberra).

5 Business Council of Australia (2009), Submission 233 to the National Health and Hospitals Reform Commission: Second Round Submissions.

6 The OECD Health Project (2004), *Towards high-performing health systems*, Summary report, (OECD: Paris).

Communications technology, the internet and higher incomes have armed us with more information and enabled us to demand more choice as consumers. We are less likely to accept decisions being made on our behalf and are more likely to exercise our right to choose an alternative. Baby boomers, and more so Gen X and Gen Y, will be less accepting of whatever is on offer; they have expectations – for up-to-date accurate information, and frank discussion of choices, associated risks and likely outcomes⁷.

Community expectations of services deemed to be government's responsibility and in the public interest will not escape this trend. But the upward pressures on health spending are unrelenting, reflecting continued advances in health care and increased demand from ageing populations and shifting disease patterns.⁸ Efficiencies have to be found if we are even to sustain our current levels of good health and longevity. We know there is variation in the performance of health services across regions and between countries. Neither system design nor funding levels are able to adequately explain this variation. Now, more than ever, policy reform must embed design levers which deliver intrinsic and continuous assessment of 'value for money'.

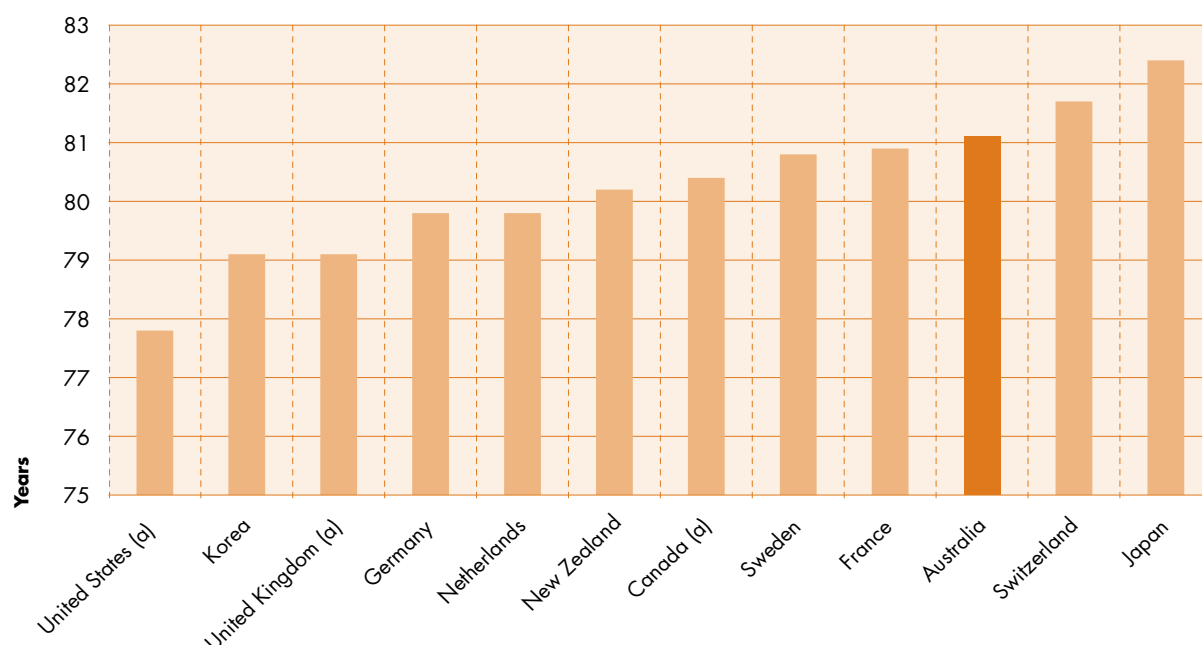
1.3. A health system under pressure

Our research and analysis over the last 16 months has led us to the conclusion that there is a constellation of problems and service gaps besetting our health care system. Before describing the symptoms and explaining the causes of our ailing health system, it is worth looking beyond our own borders to ascertain how our health system performs relative to other developed countries.

1.3.1 Assessing the performance of our health system

Compared with other OECD countries, we have better than average high level health outcomes when measured in terms of life expectancy at birth (see Figure 1.1), although when measured using infant mortality data (see Figure 1.2), outcomes are only average.

Figure 1.1: Total population life expectancy at birth – 2006



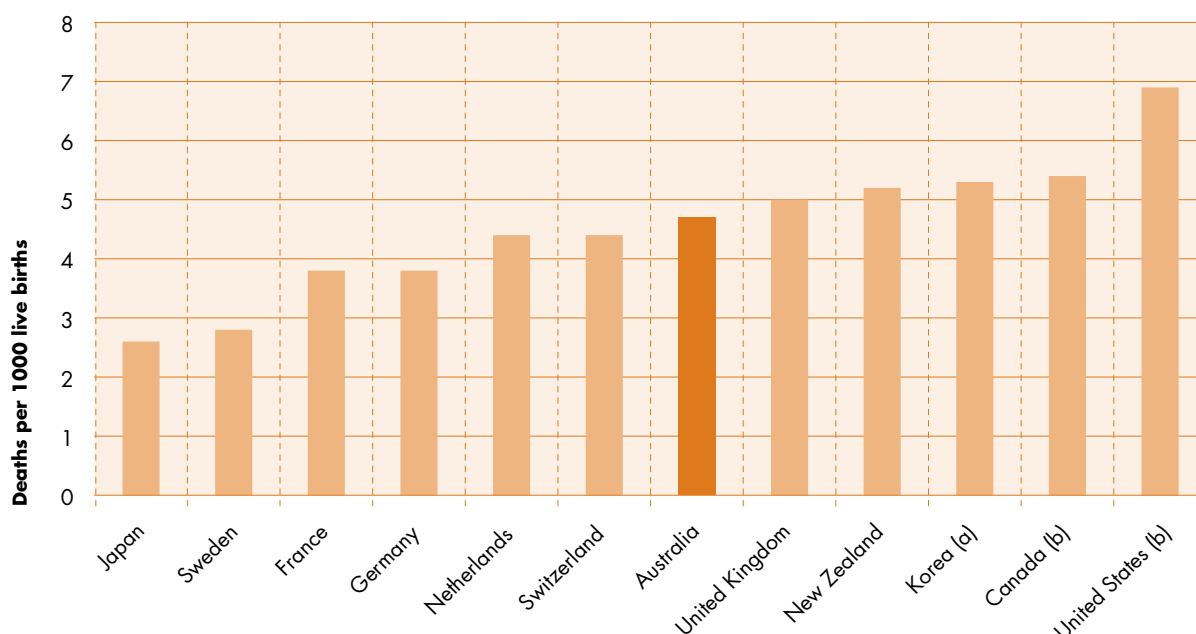
Note: (a) 2005 data

Source: OECD Health Data 2008 – Version: December 2008

7 SJ Duckett (2009), 'Are we ready for the next big thing?', Medical Journal of Australia, 190(12).

8 The OECD Health Project (2004), Towards high-performing health systems, Summary report, (OECD: Paris).

Figure 1.2: Infant mortality – 2006

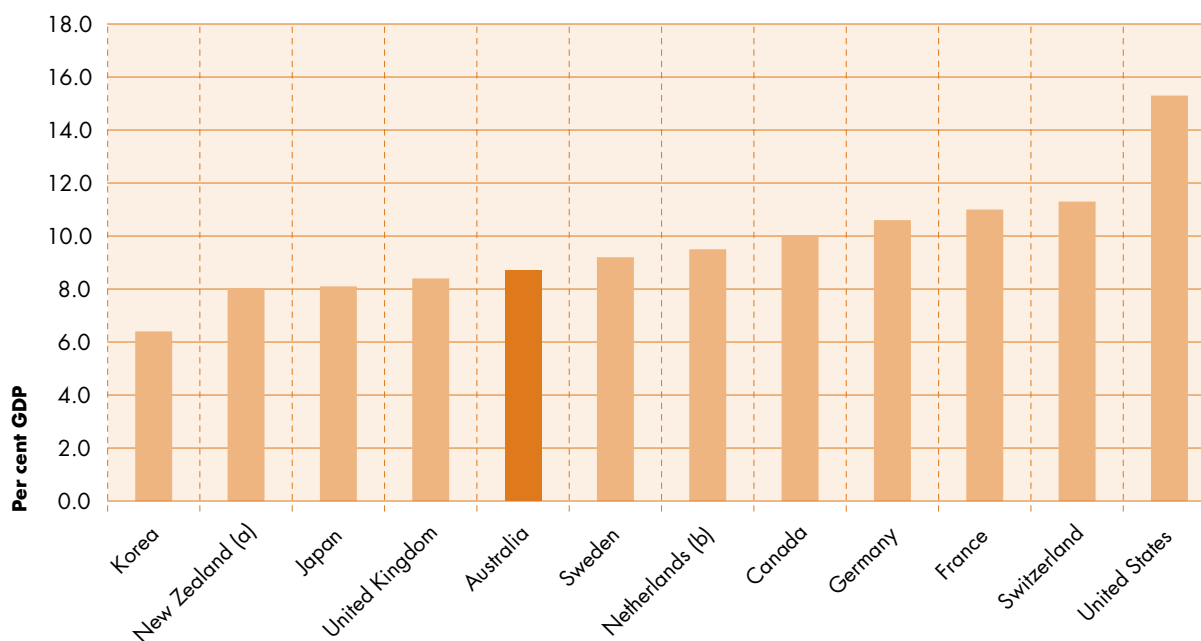


Note: (a) 2002 data; (b) 2005 data.

Source: OECD Health Data 2008 – Version: December 2008

The latest international comparison shows that, in 2006–07, Australia spent 8.7 per cent of GDP on health, a little less than the OECD median (9.0 per cent) and quite a bit less than the weighted average (11.2 per cent) of 29 countries (see Figure 1.3).

Figure 1.3: Total expenditure on health care in OECD countries – 2006



Note: (a) 2003 data; (b) 2004 data. Data do not include expenditure on aged care.

Source: OECD Health Data 2008 – Version: December 2008

The *World health report 2000 – Health systems: improving performance*⁹ compared aspects of health system performance from around the world. In this report, Australia ranked 39th on 'level of health' (disability-adjusted life expectancy) and 32nd on 'overall health performance' (relation of overall health system achievement to health system expenditure) out of 191 member states.

This may provide some comfort that our health system is doing well enough based on macro indicators, but what do our patients and doctors tell us? Cross-national surveys of patients and primary care doctors offer a unique perspective that is often missing from international studies of health system performance. The Commonwealth Fund provides us with some insight into Australia's relative performance on a range of measures (see Figure 1.4).¹⁰ This composite scorecard comprising 69 indicators of performance derived from three surveys suggests that Australia has some work to do, particularly in the areas of quality of care and efficiency, while performance on access is only average.

Figure 1.4: Six nation summary scores on health system performance

Overall ranking		AUS	CAN	GER	NZ	UK	USA
Overall ranking – 2004 edition		2	4	n/a	1	3	5
Overall ranking – 2006 edition		4	5	1	2	3	6
Overall ranking – 2007 edition		3.5	5	2	3.5	1	6
Measure	Quality Care	4	6	2.5	2.5	1	5
	Right Care	5	6	3	4	2	1
	Safe Care	4	5	1	3	2	6
	Coordinated Care	3	6	4	2	1	5
	Patient-centred Care	3	6	2	1	4	5
	Access	3	5	1	2	4	6
	Efficiency	4	5	3	2	1	6
	Equity	2	5	4	3	1	6
	Healthy Lives	1	3	2	4.5	4.5	6
	Health Expenditure per capita*	\$2,876	\$3,165	\$3,005	\$2,083	\$2,546	\$6,102

Note: 1=highest ranking; 6=lowest ranking

*Health expenditures per capita figures are for 2004 except for Australia and Germany (2003) and are adjusted for differences in cost of living.

Source: Extracted from: K Davis, C Schoen, S Schoenbaum et al (2007), *Mirror, mirror on the wall: an international update on the comparative performance of American health care*, (The Commonwealth Fund: New York).

Note: Telephone surveys conducted in six countries in 2004 examined the primary care experiences of nationally representative samples of adults. Surveys conducted in 2006 target representative samples of "sicker adults", while the 2007 survey looks at the experiences of primary care physicians.

Another survey conducted in Australia in 2007 on public perceptions of Australia's doctors, hospitals and health care systems found generally positive perceptions on most aspects. However, views were mixed about whether hospitals with private facilities were 'trusted' more than public hospitals. The study concluded that 'all Australians endorsed the current Medicare system but overwhelmingly favoured a more socially responsive public health system, funded by the public purse, to provide quality care for all'.¹¹

During the public consultations we conducted in 2008-09, we frequently, and consistently, heard that many people had difficulty getting medical and dental attention in a timely fashion at a convenient location at an affordable cost; that longer-term health care was often uncoordinated and difficult to navigate; and that confidence in our hospital system was wavering. Health professionals spoke about constraints on their capacity to meet patients' needs according to their own expectations, patchy teamwork and leadership, and their frustration with red tape, bureaucracy and the slow progress of the e-health agenda.

9 World Health Organisation (2000) *World health report 2000 – Health systems: improving performance*, (WHO: Geneva).

10 K Davis, C Schoen, S Schoenbaum et al (2007), *Mirror, mirror on the wall: an international update on the comparative performance of American health care*, (The Commonwealth Fund: New York).

11 EA Hardie and CR Critchley (2008), 'Public perceptions of Australia's doctors, hospitals and health care systems', *Medical Journal of Australia*, 189(4).

In recent times, the newspaper headlines in Australia have heralded the injustice of unequal access to health care experienced by rural and Aboriginal and Torres Strait Islander peoples, the mentally ill, and the disadvantaged, as well as reporting worrying and repeated calamities occurring in hospital emergency departments.

“ *The stories become unconscionable in any society that purports to serve the needs of ordinary people, and, at some alchemical point, they combine with opportunity and leadership to produce change. Britain reached this point and enacted universal health-care coverage in 1945, Canada in 1966, Australia in 1974.*¹²

All of what we heard and read helped us to consider the question: is our health care system still fit for purpose and will it sustain us into the future? Or has Australia reached a second tipping point?

Our Interim Report explored this question in some detail and found that, while for most people the current health system performs well, there are many areas of health inequity, service gaps, poor access, inefficiency and inconsistent performance requiring urgent reform. We also reported an underlying requirement for long term structural reform if we wish to continue to have internationally enviable health outcomes into the future. Many respondents to the Interim Report felt similarly. The Menzies Centre for Health Policy provided this viewpoint:

“ *The interim report's perspective is that the system needs a major overhaul. We concur – there is sufficient evidence of its failure to deliver quality, value for money, accessibility, and equity to warrant a transformation. Again, this is not unique to Australia: there is remarkable consensus internationally that this is the case.*

*The need for reform is a necessary but not sufficient condition for its achievement. Australia is a federal country where health care responsibilities are unusually fragmented and interest groups are (not so unusually) powerful. In such arrangements one cannot discuss health reform in isolation from Constitutional law, Commonwealth-State relations, taxation power, political sensitivities, administrative structures, practice cultures, and a whole host of related variables. Practically speaking, it is to be hoped that major substantive change is possible without major structural change. But practically speaking, that may not be possible.*¹³

In the following sections, we outline what concerns us now and what we can reasonably predict will challenge the viability of our health and health care system well into the future. In essence, we explain why we came to the conclusion that we have, in fact, reached a second tipping point.

12 A Gawande (2009), Getting There from Here. How should Obama reform health care? The New Yorker January 26, 2009.

13 Menzies Centre for Health Policy (2009), Submission 199 to the National Health and Hospitals Reform Commission: Second Round Submissions.

1.3.2 A system out of balance

There is a focus on illness at the expense of wellness

As research provides us with more and more answers to the causes of disease, we are becoming increasingly aware that aspects of our modern lifestyle may be detrimental to our health. But it is difficult for many Australians to make healthy choices in the way they live their lives because of their socio-economic circumstances or their living environment. In 2006–07, Australians spent about \$94 billion on health. However, the proportion of this spent on preventing illness was estimated to be less than two per cent of this total.¹⁴ Chronic diseases are common. In 2004–05, 77 per cent of Australians had at least one long term condition. In previous years, chronic conditions were estimated to consume about 70 per cent of the sector's spending and yet the emergence of many of these chronic conditions is influenced by potentially modifiable lifestyle or risky behaviours.¹⁵ In essence, we commit less than two per cent of the health budget to a problem which consumes a major proportion of health expenditure.

We have a health system skewed to managing sickness rather than encouraging wellness. There is no nationally coordinated mechanism to deliver prevention and health promotion services on the scale required to impact significantly on the cost of chronic disease. And the structure of the Medicare Benefits Schedule principally subsidises one-off visits to manage and diagnose health problems, rather than looking after a patient over a time period or keeping the patient well.

The workplace, in particular, is a missed opportunity to support the health and wellness of employees given the captive audience and the clear alignment of incentives to maintain a healthy workforce and reduce loss of productivity.¹⁶ Traditional employment practices focus on reducing the risk of employing a person who has an illness and rehabilitating the injured, rather than putting sustained effort into ensuring that the existing workforce remains healthy and energised.

There is not a level playing field when it comes to funding community based activities, allied health care, and preventive activities compared with funding pharmaceuticals through the Pharmaceutical Benefits Schedule (PBS) and medical services through the Medicare Benefits Schedule (MBS)¹⁷. Even though some services provided by allied health professionals might be more effective than medical or pharmaceutical treatments, they are not utilised as often because they are not included on the PBS or MBS.

A growing tension between private and public provision

One of the strengths of the Australian health system is that it has a combination of private and public financing as well as a competitive mix of private and public health care delivery. Nonetheless, there are signs that the competitive tension between private and public hospitals has become unbalanced. More and more, patients who can afford it are seeking planned surgical and procedural care in the private sector as they face long waiting lists and competing demands for emergency care in public hospitals. The attraction of better financial rewards and conditions in the private sector has resulted in surgeons and other proceduralists moving increasingly or exclusively to the private sector.

There are increasing concerns that a two-tiered health system is evolving, in which people without private health insurance have unacceptable delays in access to some specialties such as cataract surgery and joint replacements.

The system is provider focused, rather than patient focused

There is also a justifiable criticism that our health system tends to be structured around providers rather than the people they serve. The 'balance of power' in a knowledge intensive and technically complex system rests with the experts and health organisations. Currently, it is usually the patient who must find a way of seeing multiple health professionals while navigating across various locations, rather than health professionals functioning as a team practising together and providing care around the whole needs of a person.

14 Australian Institute of Health and Welfare (2008), Australia's health 2008. Cat. no. AUS 99. (AIHW: Canberra).

15 Australian Institute of Health and Welfare (2006), Chronic diseases and associated risk factors in Australia, 2006. (AIHW: Canberra).

16 J Lang (2008), Workshop Paper – Prevention and Wellness. Discussion Paper commissioned by the National Health and Hospitals Reform Commission.

17 L Segal (2008), A vision for primary care: Funding and other System Factors for optimising the primary care contribution to the community's health, Discussion Paper commissioned by the National Health and Hospitals Reform Commission.

A disjunction between service provision, teaching and research

Education, training and research are fundamentally critical to the sustainability of our health system. Pressures on hospitals to care for patients, reduce costs, improve quality and meet growing consumer expectations are exacerbated by an ageing workforce, greater teaching and training commitments, and calls for increased clinical leadership in research and governance.

These pressures have also caused a rift between the corporate and clinical accountabilities of hospitals. Health service managers struggle daily to meet tight budgets and reduce waiting lists while clinical leaders strive to balance patient service obligations with their responsibilities as teachers, trainers and researchers. As pointed out in the Garling Report on acute care services in NSW public hospitals:

“ During the course of this inquiry, I have identified one impediment to good, safe care which infects the whole public hospital system. I liken it to the Great Schism of 1054. It is the breakdown of good working relations between clinicians and management which is very detrimental to patients. It is alienating the most skilled in the medical workforce from service in the public system.¹⁸

1.3.3 Inequities in access and outcome

Inconsistent and unequal access to appropriate services and health outcomes is causing many Australians unnecessary suffering. The Australian way is to give all a ‘fair go’ and we know that this is not the case for many people.

The life expectancy gap for Aboriginal and Torres Strait Islander peoples

New figures released by the ABS on the difference in life expectancy at birth between Indigenous and non-Indigenous Australians have revised the estimates of ‘the gap’. The life expectancy of Aboriginal and Torres Strait Islander men and women is shorter, on average by 11.5 years and 9.7 years respectively.¹⁹ The causes of this life expectancy ‘gap’ are multifaceted, but concerted action is needed to ensure that at least the health system is doing all in its power to remedy this injustice.

People living with mental illness are poorly supported

In Australia, many people who have a mental illness do not seek care. Young people are particularly reluctant to seek treatment within traditional paradigms of care and yet early intervention is known to make a difference for many disorders. Neither are people with a mental illness well supported in the community, yet we know that assisted housing, employment support, directed education and training help prevent episodes of mental illness and aid recovery from such episodes. Australia performs particularly poorly when it comes to supporting workforce participation for those people with a mental disorder who wish to work.

Remoteness leads to poorer health outcomes

The almost one third of Australians living in remote and rural areas are at risk of poorer health status, shorter lives, higher rates of accident and injury, greater levels of illness, and lower rates of certain medical treatments. There are often fewer health services for them to choose from and a lack of basic necessities that contribute to good health such as fresh food and clean water. They must often travel long distances at great expense to themselves to access health care services only available in metropolitan centres.

18 P Garling (2008), Final report of the Special Commission of Inquiry: Acute care services in New South Wales public hospitals, (NSW Government: Sydney).

19 Australian Bureau of Statistics (2009), Experimental Life Tables for Aboriginal and Torres Strait Islander Australians, 2005–2007, Cat No 3302.0.55.003. (ABS: Canberra).

A health care system without 'teeth'

Basic dental care is unaffordable for many Australians, yet we know that the condition of our gums and teeth affects our overall health, wellbeing and quality of life. The absence of early intervention for common, preventable oral diseases such as tooth decay and gum disease results in thousands of avoidable hospital admissions. Those who cannot afford to see a private dentist often wait two years to access care through the public dental system. Significant out-of-pocket costs are incurred by those who are forced to seek and fund private dental care. Worse, despite years of improvement in the dental health of Australia's children, there appears to have been a recent increase in tooth decay among primary school aged children.²⁰ Indigenous children, children living outside major cities, and those living in the most socio-economically disadvantaged areas are at a particularly increased risk of poor dental health.

These failings of social justice have immediate quality of life implications for individuals and communities as well as longer term productivity implications for our nation as a whole. Confronting and removing barriers to accessing necessary oral health and dental care will undoubtedly provide the opportunity for better health, enhancing the quality of life and the capacity of every individual to contribute productively to society.

1.3.4 Inefficiencies in the organisation and delivery of health care

Many people think that efficiency is just about money and getting the lowest price. But the importance of efficiency in the health care system is much more than this, not only because it is key to delivering an affordable and sustainable health system, but also because it can be an ethical issue in terms of equity and fairness. If waste occurs – whether through duplication, poor processes, unnecessarily high cost inputs, errors, high administrative costs, or spending on ineffective treatments – it will adversely impact other people's access to health care in a system with finite financial, capital and human resources.

Since our Interim Report, we have spent considerable time examining the evidence for waste and inefficiency within our health system. A background paper²¹ prepared for us suggests that there is considerable potential to increase the efficiency and effectiveness of our health care system in Australia²². Studies estimate that our average life expectancy at birth could be increased by just under two years, or the number of health services increased by 10 to 20 per cent using the same amount of resources. In 2006, the Productivity Commission estimated that just a five per cent improvement in health sector productivity could result in net savings of around \$3 billion. Here we highlight some areas of potential efficiency gain.

Variation in hospital costs per patient

The sheer size of the hospital sector in expenditure terms and the complexity of payment arrangements make it a likely target for seeking efficiency improvements. It has been estimated that the productivity gap between current and optimal efficiency in the hospitals sub-sector might be in the order of 20–25 per cent²³. It is apparent that there is considerable variation between state public hospitals in the costs per patient, suggesting that there is clearly room for improvement (see Figure 1.5) in some states.

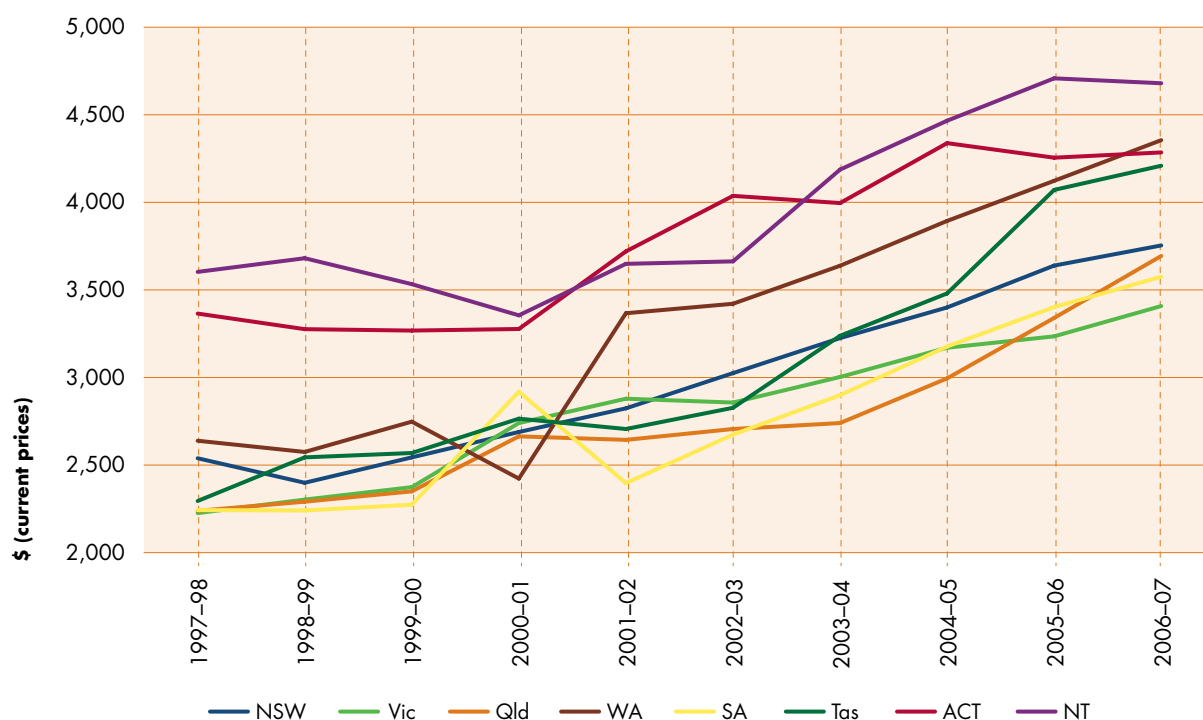
20 Australian Institute of Health and Welfare (2009), *A Picture of Australia's Children*, 2009, (AIHW: Canberra).

21 National Health and Hospitals Reform Commission (2009), *The Australian health care system and the potential for efficiency gains: A review of the literature*, Background Paper.

22 National Health and Hospitals Reform Commission (2009), *The Australian health care system and the potential for efficiency gains: A review of the literature*, Background Paper.

23 Productivity Commission (2006), *Potential Benefits of the National Reform Agenda*, Report to the Council of Australian Governments, (Productivity Commission: Canberra).

Figure 1.5: Recurrent cost per casemix-adjusted separation, selected public hospitals



Source: National Hospital Cost Data Collection, various years

Primary care delivery could be more efficient

Compared to other OECD countries, Australia's primary health care system consistently performed above the OECD average in each of the three decades of data²⁴. However, in recent years, other countries have been overtaking us. This may suggest that we have failed to improve on an already good system.

Although general practices have been growing in size in recent years, approximately 40 per cent of general practitioners are still in smaller practices of less than four practitioners.²⁵

Our literature review reinforced the notion that it is important, from an efficiency and health outcomes perspective, to build a strong primary health care sector, provided this is not done at the expense of adequate support of specialist and referral care.²⁶

Older patients in public hospitals often need a different form of care

Almost 20 per cent of older patients in public hospitals would be more appropriately cared for outside an acute hospital.²⁷ The reasons patients receive inappropriate care include lack of appropriate post-acute care services, delays in the discharge process, delays in diagnostic tests, and delays in medical and other specialised consultations.

24 J Macinko, B Starfield and J Shi (2003), The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970–1998, Health Services Research, 38(3) June.

25 C Bayram, H Britt, J Charles et al (2008), General practice activity in Australia 1998-99 to 2007-08: 10 year data tables (Australian Institute of Health and Welfare: Canberra).

26 National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, Background Paper.

27 C Poulos and K Eagar (2007), 'Determining appropriateness for rehabilitation or other subacute care: Is there a role for utilisation review?' Australia and New Zealand Health Policy, 4(3).

Aged care services could be made more efficient

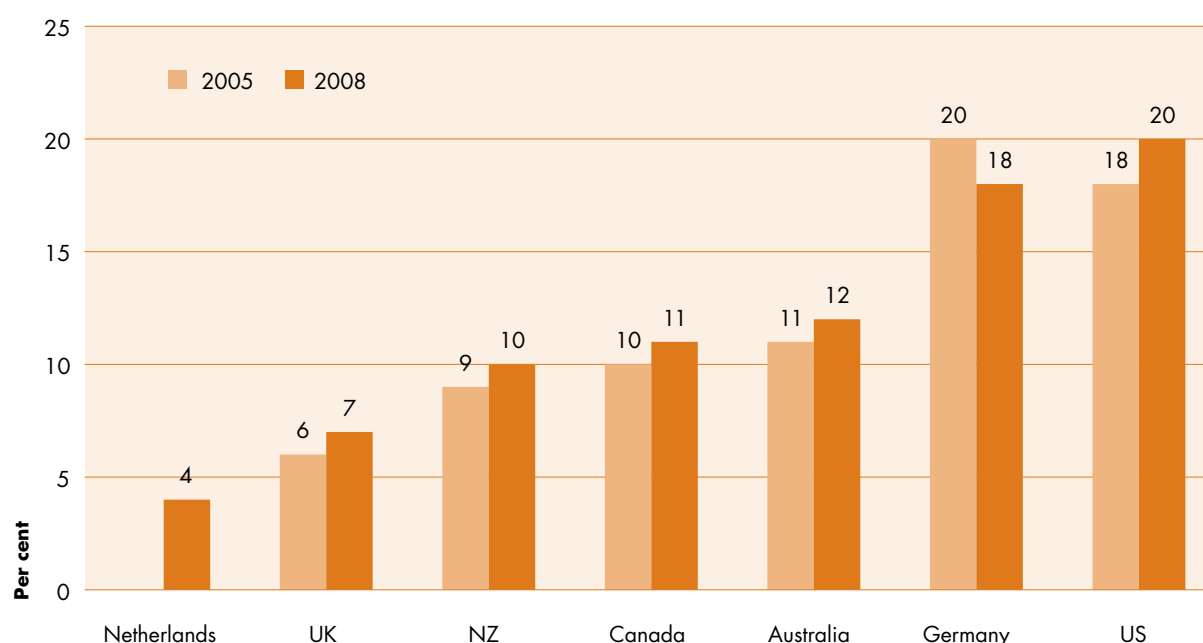
In 2003, an Australian study found that aged care services could be made up to 17 per cent more efficient if they all operated at the level of the most efficient²⁸. If this happened, providers could care for an additional 23,100 clients (at the dependency levels that existed in 2002–03). Costs could also be reduced by a further seven per cent (or \$470 million in 2002–03 prices) by making structural adjustments that improve the scale efficiency²⁹ of the sector³⁰. We note, however, that for various reasons, such as location, it is practically impossible to have all facilities operating at the most efficient cost.

Inefficient processes existing within health care could be reduced

We know that far too many diagnostic tests, medicines and procedures that are performed are unnecessary, inappropriate, and even sometimes harmful. Many are not cost-effective, lack an evidence base, or are simply duplications of tests (see Figure 1.6) previously performed because a clinician does not have access to the original results. This waste of precious resources is frustrating for consumers and clinicians alike, and has the potential to be reduced significantly.

Figure 1.6: Duplicate medical tests among sicker adults

Percentage of patients reporting that their doctor ordered a medical test that the patient felt was unnecessary because the test had already been done before (in the last two years).



Source: The Commonwealth Fund (2005 and 2008) International Health Policy Survey of Sicker Adults, <http://www.commonwealthfund.org/>

1.3.5 Growing concerns about quality and safety

Action is needed to measure and prevent adverse events

Adverse events that cause harm to a person receiving health care have received much media attention in recent times. They include infections, falls and other injuries, medication, and medical device problems and errors. Such events cause patients distress and suffering, compromise operational efficiency, and go right to the heart of the mantra held dear by all health professionals – first do no harm.

28 D Rao, T Coelli and C O'Donnell (2003), Efficiency of aged care facilities in Australia, The Centre of Efficiency and Productivity Analysis, The University of Queensland.

29 Scale efficiency is the reduction in unit cost available to a firm when producing at a higher output volume.

30 Productivity Commission (2008), Trends in aged care services: some implications, Commission Research Paper, (Productivity Commission: Canberra).

The 1994 Quality of Australian Health Care Study (QAHCS) (which has sadly not been repeated to test for improvement), found that 16.6 per cent of all hospital admissions were associated with an adverse event, of which half were highly preventable.³¹ Using the data from this study, Richardson estimated that the number of avoidable adverse events occurring each year was equivalent to 13 jumbo jets crashing and killing all 350 passengers on board.³² Using hospital separation data for 2007-08, the AIHW reported that 4.8 per cent of public and private hospital separations had a code for an adverse event.³³ Studies conducted in other countries suggest a rate of adverse events between 3.7 and 10 per cent, somewhat lower than the QAHCS findings. It is estimated that adverse events cost around \$2 billion annually. If just half these events could be prevented, a cost saving of \$1 billion would accrue.³⁴

Whatever the actual rate in Australia, there is an accumulation of evidence to suggest that simple mistakes – such as failure to wash hands between patients – to complex human or systemic errors – such as unforeseen adverse drug interactions – are too frequent and could be reduced. Poor communication – between health professionals and their patients and between health providers caring for the same patient (particularly at the point of transfer of care) – is often cited as a factor leading to preventable adverse events.³⁵ It should be noted that the greatest incidence of adverse events is not necessarily in the most costly episodes of care, but rather the high volume episodes (for example, hip surgery)³⁶.

Poor capture and use of performance data

While there are clear indications that we need to improve the efficiency of our health system, there is a critical need to develop a credible and well resourced national health data system for monitoring and comparing performance in both private and public settings. Even when data are collected, we lack a framework for making it 'smart' – comparing, analysing and reporting it back to clinicians, health services and consumers in a user-friendly format. Without smart data we cannot know either the extent of the problem, how we should target improvement efforts for best effect, or whether we have succeeded in our endeavours.

Potentially preventable hospital stays

Gains in efficiency within hospitals would be experienced if preventable hospitalisations were minimised, enabling a greater focus on those patients requiring treatment in a hospital setting. Almost 10 per cent of hospital stays are potentially preventable if timely and adequate non-hospital health care had been provided to patients with chronic conditions.³⁷

1.3.6 Structural complexity

We have a fragmented health system with a complex division of funding responsibilities and performance accountabilities between different levels of government (see Figure 1.7). This creates confusion and uneven access to services and quality of care for the consumer and cost, blame and service shifting by providers.

31 R Wilson, W Runciman, R Gibberd et al. (1995), 'The quality in Australian health care study', *Medical Journal of Australia*, 163: 458-471.

32 J Richardson (2005), 'Priorities of health policy: cost shifting or population health', *Australia and New Zealand Health Policy*, 2(1).

33 Australian Institute of Health and Welfare (2009), *Hospital Statistics 2007-08*, Health Services Series No. 33, (AIHW:Canberra).

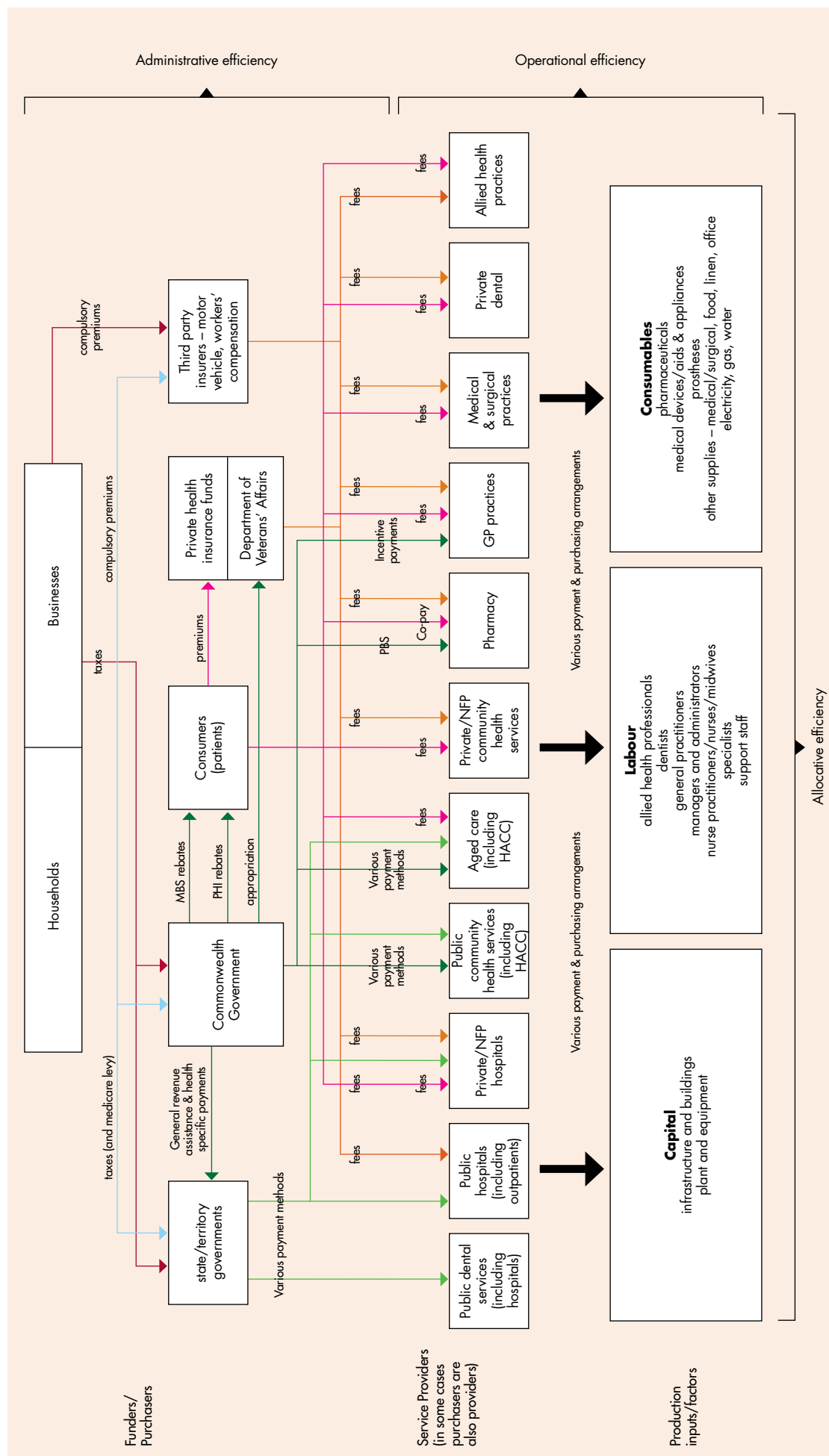
34 J Ehsani, T Jackson and S Duckett (2006), 'The incidence and cost of adverse events in Victorian hospitals 2003-04,' *Medical Journal of Australia*, 184(11):551-555.

35 K Easton, T Morgan and M Williamson (2009), *Medication safety in the community: A review of the literature*. (National Prescribing Service: Sydney).

36 J Ehsani, T Jackson and S Duckett (2006), 'The incidence and cost of adverse events in Victorian hospitals 2003-04,' *Medical Journal of Australia*, 184(11):551-555.

37 Australian Institute of Health and Welfare (2008), *Australian hospital statistics 2006-07*. Health services series no. 31. Cat. no. HSE 55. (AIHW: Canberra).

Figure 1.7: Current Australian health system structure and funding flows³⁸



38 National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, Background Paper.

The historical legacy of Federation and its divided responsibilities for the continuum of health and aged care has created tensions, inconsistencies and misalignment of reward and effort. This interplay of Commonwealth-state financial arrangements for health and aged care has created perverse incentives which allow allocative inefficiencies to become entrenched. Patient care is often driven by funding flows rather than clinical best practice.

As we concluded in our first report:

“Lack of clarity of accountability and definition of responsibilities creates the environment for a blame game, as each government is able to blame the other for shortcomings attributed to each other's programs. The losers are the public who wait longer for care or don't have their service needs met.”³⁹

1.4 Future challenges to our health system

While the 'diagnostic' above provides us with good reason to consider major change to the structure and functioning of our health system, what of emerging challenges to our health status and the continued effectiveness of health care provision?

Australia is indeed fortunate to have some excellent sources of data collected and reported by the AIHW and the ABS, which provide helpful 'windows to the future' via population projections, socio-economic trends and anticipated changes in disease patterns. Positioning the health system to deal with the future takes time, so we need to prepare now for these emerging challenges.

1.4.1 Expenditure on health care

What drives health expenditure?

Health and aged care costs are rising around the world and will continue to do so. In Australia, expenditure on health and residential aged care as a percentage of GDP is projected to rise from 9.3 per cent in 2002–03 to 12.4 per cent of GDP by 2032–33.⁴⁰

Historical analysis shows a startlingly close relationship between a country's wealth (measured as GDP per capita) and health care expenditure. In a sense, per capita economic growth is the engine that determines the bulk of the change in health care spending. It has been suggested that income growth might explain 40-50 per cent of the total increase in health expenditure.⁴¹

However, other factors also drive the rate of health expenditure including social norms, technology and changes in demography. These factors determine the position of the health care spending curve relative to economic growth. For Australia and other OECD countries, it has been on average two percentage points above GDP for the last 50 years.⁴²

Increases in the volume of services per treated case are projected to account for half this increase.⁴³ Introduction of new technologies (including techniques, drugs, equipment and procedures used in diagnosing or providing health care) and changes in treatment practices have been the main contributors to changes in volume per case in the past, and this is expected to continue.

Population ageing and the absolute increase in population (mostly due to migration) will account for almost another quarter each (as a rule of thumb, a person over the age of 65 consumes on average

39 National Health and Hospitals Reform Commission (2008), *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements*.

40 J Goss (2008), *Projection of Australian health care expenditure by disease, 2003 to 2033*, Health and expenditure series Number 36, (AIHW: Canberra). Discussion paper commissioned by the National Health and Hospitals Reform Commission.

41 OECD (1994), *Health Care Reform: Controlling spending and increasing efficiency*, Economics Department Working Papers no. 149.

42 J Drouin, V Hediger, N Hanke et al (2008). *The health care century* in Health International No. 7 produced by McKinsey & Company.

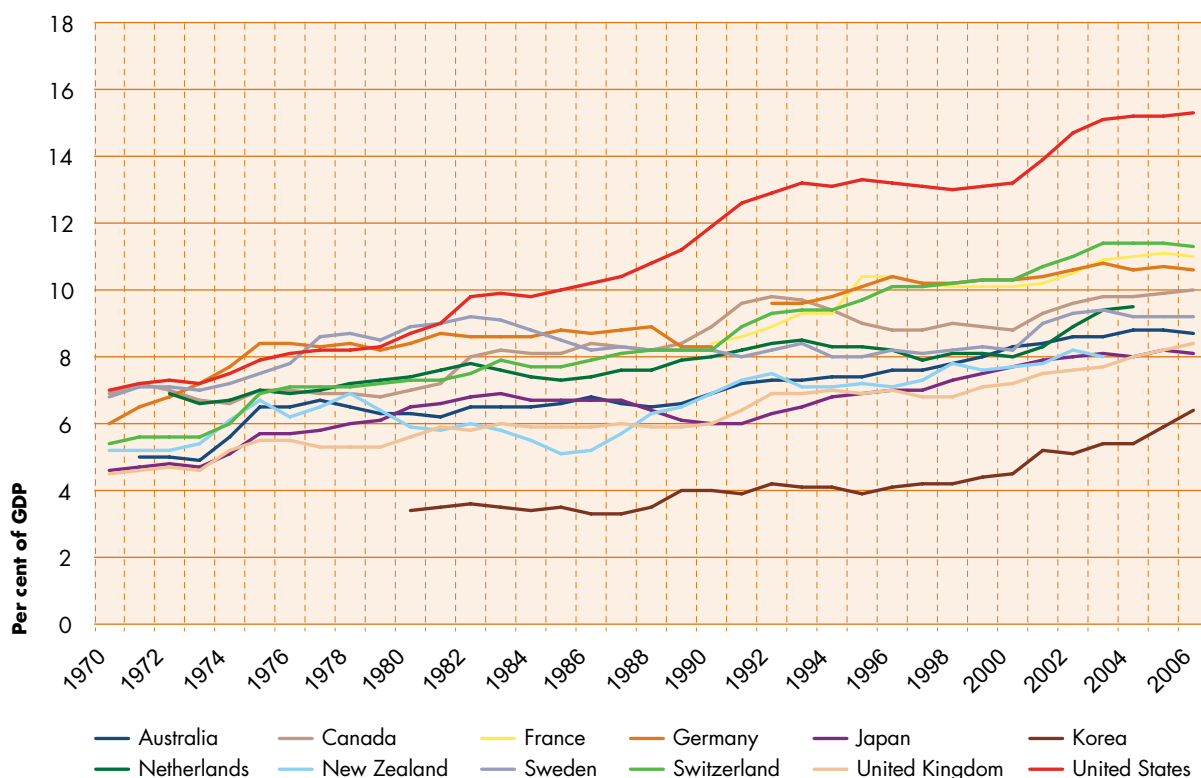
43 Australian Institute of Health and Welfare (2008), *Projection of Australian health care expenditure by disease, 2003 to 2033*, Health and expenditure series Number 36, (AIHW: Canberra). Discussion paper commissioned by the National Health and Hospitals Reform Commission.

four times as much health care as those below 65).⁴⁴ Other non-demographic factors account for the balance. Left unconstrained, health care costs will rise dramatically and, while policymakers might struggle to identify a threshold above which spending cannot rise, it is clear that many consider current spending growth unsustainable.

Is growth in health expenditure really a problem?

Health care costs have been increasing steadily over time in all OECD countries (see Figure 1.8) and, understandably, limiting health expenditure has been uppermost in the minds of successive governments.

Figure 1.8: Health care expenditure as a proportion of GDP for 12 OECD countries



Source: OECD (2008), OECD Health Data 2008, Version: December 2008.

We often hear worrying reports about the rising costs of health and how it is unsustainable and may bankrupt governments. In fact, some state governments have predicted that if health expenditures continue to rise at current rates, it will consume 100 per cent of their budgets by 2033.⁴⁵ However, we need to give some thought to whether this is truly the case. Evidence does tell us that some countries' health systems are not providing value for money. That is, for the amount of money they are spending they could be getting better health outcomes.

It is reasonable to conclude that there is no optimal amount that we should be spending on health services provided that the benefits outweigh the costs, however calculated. As market forces are unable to operate fully in health care, due to issues of equity and access, this opens up the role for government (and society) to put a value on the costs and benefits and ensure that desired health outcomes are achieved efficiently and effectively. As individuals demand more health care and expenditure grows as a proportion of GDP, Australians will need to decide as a society who is best placed to fund this growth, and in which areas of health and aged care.

44 H Oxley and M MacFarlan (1994), Health care reform: Controlling spending and increasing efficiency, OECD Economics Department Working Papers, no 149, at: <http://www.oecd.org/dataoecd/32/20/1862400.pdf>

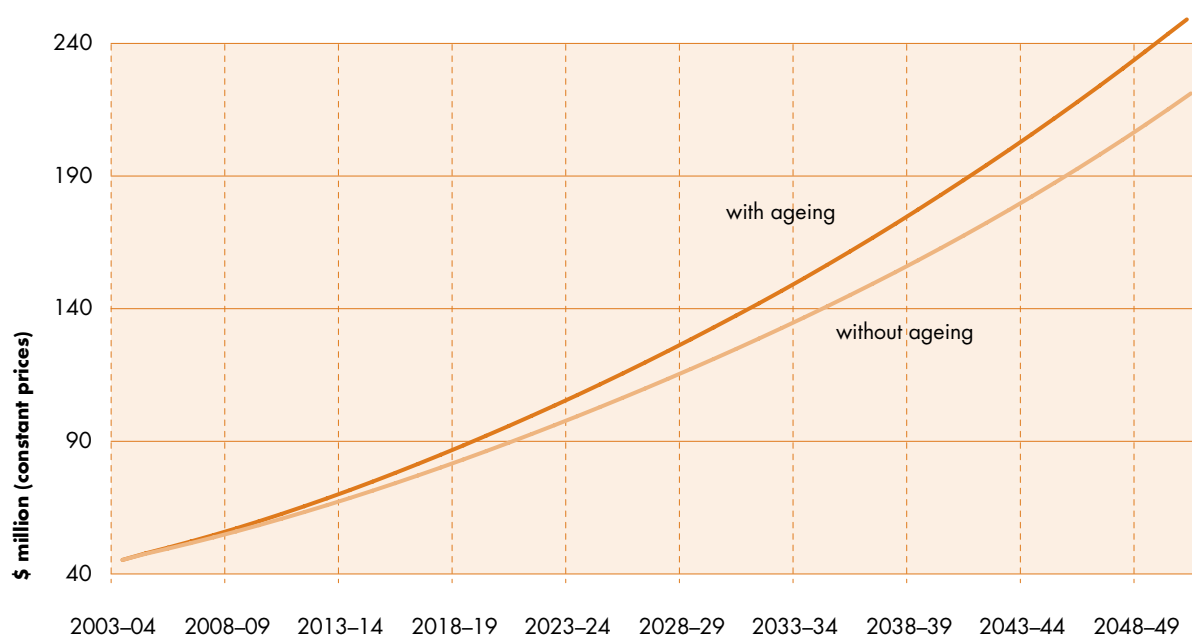
45 For example, New South Wales; see New South Wales (2008) Auditor General, Performance Audit: Out of hospital Programs, Sydney.

1.4.2 Demographic trends

Our population is ageing

As a result of lower fertility and better health, more Australians are now older and they live for longer. The number of people over 85 is forecast to quadruple to 1.6 million by 2047⁴⁶ and comprise 5.6 per cent of the population. The rate of increase in the proportion of our population aged over 65 years and over 85 years is not expected to peak until 2020, with the most rapid increase in deaths occurring between 2027 and 2037⁴⁷. Long term projections predict that, by 2035, the rate of deaths will overtake the birth rate and we will be totally reliant on migration for the population to grow. Population ageing is expected to place increasing upward pressure on government spending (see Figure 1.9) and put significant additional demands on our health and aged care systems.

Figure 1.9: Population ageing and government health spending



Source: Productivity Commission (2005), Impacts of Advances in Medical Technology in Australia, Research Report, Melbourne. http://www.pc.gov.au/__data/assets/pdf_file/0005/17168/medicaltechnology1.pdf

Counter to this rise, the proportion of children aged 0-14 years will reduce from 19.1 per cent in 2007 to 15 per cent in 2047 as fertility rates continue to remain below replacement rate. Consequently, more people will be frail and will look for assistance from informal carers, yet they will be busier than ever earning a living to meet rising costs of living and their own retirement needs. For each older person in 2007, there were five working-age people, while in 2056 there will be less than three working-age people for every older person⁴⁸. In addition to health specific implications such as constraining the supply of informal carers and potential participants in the health workforce, this trend will reduce the taxation base required to fund governmental expenditure on health care.

46 Productivity Commission (2008), Trends in aged care services: Some Implications, Productivity Commission Research Paper (Commonwealth of Australia: Melbourne).

47 Australian Bureau of Statistics (2009), Australian social trends, Cat. No. 4102.0.

48 Australian Bureau of Statistics (2009), Australian social trends, Cat. No. 4102.0.

The impact of longevity

Our average life expectancy is currently among the highest in the world and has increased by five years over the last two decades⁴⁹. Based on assumed improvements in mortality, on average, men aged 65 in 2047 could live 3.7 years longer than those aged 65 in 2007 and women 2.8 years longer, although this does not say anything about the quality of these additional years. Increased life expectancy will delay end of life costs but it will increase total costs as a result of the increased number of people requiring services and treatment to help with mobility, hearing, eyesight and general frailty. It has been calculated that the average PBS costs for a person aged 65–74 are more than 20 times greater than those for a 15–24 year old⁵⁰.

The way people work and play is changing dramatically, impacting on health

Changing lifestyle preferences are resulting in more people working from home, enabled by technology and advances in communication. Many of those heading for retirement will wish to work part-time as they age.⁵¹ These changes will have implications for our health workforce as well as for individuals who may lack the social interaction and support services provided in traditional working environments. On the positive side, it is expected that Generation Y will be more involved in voluntary work, which may help fill future gaps in our caring workforce.

Families are changing

Over the last two decades, the ABS⁵² has reported a small decline in the proportion of adults living with a partner. The number of lone person households is expected to increase at a rate of between 1.7 per cent and 3.1 each year over the next decade or more. This trend is perhaps related to the increased financial and social independence of women as well as the ageing of the population, tendencies to partner at a later age, and easier access to divorce. Given these, and other trends already mentioned, it is no wonder that experts are also predicting an increase of between 53 and 70 per cent in the number of couple families without children. It is anticipated that traditional family households will decline in number from 75 per cent in 2001 to 62–69 per cent in 2026⁵³ while lone parent families will increase significantly. It is known that lone parent households exhibit higher mortality rates, lower levels of health, and lower income levels.

1.4.3 Workforce shortages and declining morale

Shortages of health professionals

The adequacy of the workforce across a number of health professions is troubling us now and, combined with our ageing workforce, will make it even more difficult to meet increasing demands for health care into the future. It is estimated that, in 2006, those employed in the health service industry comprised 7.3 per cent of all employed persons⁵⁴ but we may need to have over 20 per cent of the total workforce in health related areas by 2025 if we are to maintain delivery of services that we currently have.⁵⁵

The current distribution of the health workforce across Australia does not match the population distribution. General practitioners, medical specialists, dentists and physiotherapists are particularly poorly distributed in regional and remote Australia, resulting in difficulty meeting current, never mind future, health care needs.⁵⁶ Added to this conundrum is our already heavy reliance on overseas trained health professionals (41 per cent of rural doctors were trained overseas⁵⁷) and our rapidly ageing and retiring health workforce. We also rely heavily on unpaid primary carers (the 'invisible' health workforce) who may dwindle in the future as more people age and rely on family members to participate in the paid workforce.

49 Australian Bureau of Statistics (2007), ABS Deaths, Australia 2007, Cat. No. 3302.0.

50 Commonwealth Government (2007), Intergenerational report 2007, (Commonwealth of Australia: Canberra).

51 Australian Bureau of Statistics (2009), Australian social trends, Cat. No. 4102.0

52 Australian Bureau of Statistics (2009), Australian social trends, Cat. No. 4102.0

53 Australian Bureau of Statistics, Household and Family Projections 2002–2026.

54 Australian Institute of Health and Welfare (2008), Australia's health 2008 (Australian Institute of Health and Welfare: Canberra).

55 P. Brooks, L. Robinson and N. Ellis (2006), 'Task substitution: where to from here?' Medical Journal of Australia (185):18–19.

56 Productivity Commission (2005), Australia's Health Workforce, Research report, (Productivity Commission: Melbourne).

57 Australian Government Department of Health and Ageing (2008), Report on the Audit of Health Workforce in Rural and Regional Australia (Commonwealth of Australia: Canberra)

Declining morale

Many health professionals have expressed dissatisfaction and weariness for the system in which they work, and are looking for leadership and reform to set the ship back on the right course. For hospitals, in particular,

“... there is a pervasive sense of loss – loss of control, loss of direction, and loss of ownership by... health professionals, politicians and the community they are meant to serve.”⁵⁸

Given that most of the recurrent cost of health care provision relates to the payment of well-trained and dedicated health professionals and support staff, it is vital that they remain engaged and motivated. We must do more to cultivate inspired clinical leadership, excellent health managers and ensure that efforts and good ideas are appropriately rewarded.

1.4.4 Chronic health conditions

Chronic conditions affecting our health are more prevalent than ever before

Over the last century, chronic disease has become more prominent than infectious disease as a cause of death; this trend is likely to continue. It has been estimated that almost four in five Australians have at least one long-term or chronic health condition ranging from asthma and arthritis to depression and diabetes.⁵⁹ Already, more than 50 per cent of GP consultations are for people with a chronic condition such as heart disease, cancer, neurological illness, mental disorders and diabetes.⁶⁰ Expenditure on chronic disease in Australia accounts for nearly 70 per cent of total health expenditure on disease.⁶¹ In the future, as the population grows and ages, more people will suffer from chronic disease, some as a consequence of unhealthy behaviours.

We know that many chronic diseases are preventable. Smoking, excessive alcohol, lack of physical activity and low fruit and vegetable consumption are all risk factors which contribute to the burden of chronic disease. In fact, 32 per cent of Australia's health burden has been attributed to these risky behaviours and choices.⁶² Good progress has been made in reducing the incidence of some chronic diseases, particularly coronary heart disease and stroke. Of concern, however, 54 per cent of adult Australians⁶³ and one in four children⁶⁴ are now overweight or obese and at risk of developing chronic disease, such as diabetes, heart disease and cancer. If current trends continue, nearly three-quarters of the Australian population will be overweight or obese by 2020.

Good health is therefore about more than health care. Governments must take action to nudge people towards health-promoting behaviours through better information, evidence-based prevention and health promotion programs (such as QUIT, the National Tobacco Strategy, and SunSmart) and to create the environments which 'make healthy choices easy choices' for every individual.

For many people, their long-term health problems may have been with them from birth, have resulted from an injury or as a consequence of a major illness, or be part of the ageing process. People with genetic disorders such as cystic fibrosis and haemophilia, chronic conditions such as asthma and schizophrenia, frailty and dementia, or physical and intellectual disabilities require a varying range of health and social care. For these people, their carers and their families there are major challenges in navigating through multiple providers of health and home care.

58 MB Van Der Weyden (2009), 'In the wake of the Garling inquiry into New South Wales public hospitals: a change of cultures?' *Medical Journal of Australia*, 190 (2).

59 Australian Institute of Health and Welfare (2006), *Chronic diseases and associated risk factors in Australia, 2006*, (AIHW: Canberra).

60 Australian Institute of Health and Welfare (2006), *Chronic diseases and associated risk factors in Australia, 2006*, (AIHW: Canberra).

61 Australian Institute of Health and Welfare (2006), *Chronic diseases and associated risk factors in Australia, 2006*, (AIHW: Canberra).

62 National Preventative Health Taskforce (2008), *Australia: the healthiest country by 2020 A discussion paper*. Canberra.

63 Australian Institute of Health and Welfare (2006), *Chronic diseases and associated risk factors in Australia, 2006*, (AIHW: Canberra).

64 National Preventative Health Taskforce (2008), *Australia: the healthiest country by 2020 A discussion paper*. Canberra.

All Australians suffering from chronic illness require a range of health services delivered by a variety of health professionals across the spectrum of primary, secondary and tertiary health care. Navigation through the health system for a person with chronic disease is complex. People often fall between the 'care gaps' and 'handovers' between care givers.

A person with a chronic illness or serious condition in Australia,

“... by and large, has a miserable existence in trying to organise their health care and prevent further deterioration.”⁶⁵

Unless we are better able to reduce pre-disposing risks and connect the care journey, chronic disease will impose a substantial and increasing burden on our health system and, importantly, reduce quality of life for many Australians and their families.

1.4.5 Advances in technology

Health technology

Advances in health technology have contributed greatly to better diagnosis and treatment, but at a cost. While in most other industries, new technology improves productivity, incremental improvements in life expectancy through treatments and cures for previously fatal conditions come at an increasing cost as the diseases that are now simpler to treat give way to more complex diseases such as dementia and cancer.⁶⁶ Technology has opened up possibilities for patients to seek more accurate diagnoses and cures where there were none before. For example, the life expectancy for women with breast cancer, who have been diagnosed and treated early, now equals those who have never had the disease⁶⁷.

The Productivity Commission argues that, overall, advances in medical technology have provided value for money, particularly as people highly value improvements in their quality and length of life. However, it notes that:

“Such technological advances, interacting with (and encouraged by) increasing demand for health services driven by income growth, accelerating population ageing, community expectations that new technologies will be accessible to all, the commitment of doctors to offer the best-available treatments, and subsidised consumer prices, will make for a potent mix, placing increasing pressures on the private and public health systems.”⁶⁸

The critical question is whether the benefits of medical technologies outweigh the costs. As health care is purchased largely by governments and insurers on behalf of patients, it is difficult for patients to easily judge whether the benefits of an intervention or an episode of health care outweigh the costs.⁶⁹ As the population ages and consumer expectations rise, more people will demand access to expensive emerging technologies while, at the same time, the number of people working to pay the bills shrinks. Health technology assessment techniques which evaluate value for money will be pivotal to weighing up the relative costs and benefits on behalf of the consumers and taxpayers and ensuring equitable access. It has been suggested that health systems with the greatest capacity for governmental control over the introduction of, and access to, emerging technologies will fare better into the future.⁷⁰

65 A Cahill Lambert (2009), Submission 258 to the National Health and Hospitals Reform Commission: Second Round Submissions.

66 J Anscombe, (2008), Health care out of balance. How global forces will reshape the health of nations. (A.T.Kearney, Inc).

67 J Anscombe, (2008), Health care out of balance. How global forces will reshape the health of nations. (A.T.Kearney, Inc).

68 Productivity Commission (2005), Impacts of Advances in Medical Technology in Australia, Research Report, (Productivity Commission: Melbourne).

69 J Anscombe, (2008), Health care out of balance. How global forces will reshape the health of nations. (A.T.Kearney, Inc).

70 J Anscombe, (2008), Health care out of balance. How global forces will reshape the health of nations. (A.T.Kearney, Inc).

Information and communications technology

The technology with which we communicate and access information has also changed dramatically in recent times. Mobile phones, Personal Digital Assistants, and wireless computing technology have transformed the way we interact and communicate with others, known or unknown. The internet has grown to become a gigantic world-wide data and information source, wherein we can access information of our choosing in seconds.

Over 23 per cent of the world population and around 75 per cent of Australians⁷¹ now use the internet and, as a consequence, are able to learn a remarkable amount about their own health problem, its diagnosis, prevalence and treatment. This has driven consumer knowledge and patient expectation for a desired service or a particular outcome. It has also opened up opportunities to deliver health care services in a different, more time-effective way, which we have not yet fully exploited. Patient portals, electronic health record platforms, blogs, video chat, 'tweets' and the myriad of social networking possibilities such as Facebook all have the potential to alter relationships between care givers and care receivers. They may change the locus of control to the patient (to, for example, choose when to ask for advice and enable more flexible interaction, book an appointment, or view a test result) and offer the opportunity to engage in richer and deeper doctor-patient relationships.⁷² Already, some primary health care practices are exploiting these mediums to the benefit of practitioners and patients alike (see, for example **www.hellohealth.com**).

Web-based therapy and telephonic support have already been demonstrated to be helpful in supporting people who have mental disorders⁷³ and the internet is likely to deliver a plethora of innovative modes of interacting with many other health professionals. The technology to realise the elusive potential of a person controlled electronic health record, while still maintaining appropriate levels of privacy and confidentiality, is now well established. On the downside, increasing time spent alone at a computer has potential health consequences relating to lack of exercise and social isolation which may impact on health and wellbeing.

1.5 Dealing with an uncertain future

Looking back, there are many things we might have predicted that did not come to pass and many things that we now take for granted that we didn't even imagine.

In the 1960s, even the most gifted oracle could not have imagined the concept of the World Wide Web (www) and its associated search engines, never mind the speed with which it has permeated our everyday existence. The tools and technology to operationalise this concept were only pioneered in 1990, yet less than 20 years later the www can be accessed by almost a quarter of people around the world for an extraordinary range of purposes from research to booking air travel to social networking. Contrast this with the facsimile machine, the first of which was built in 1862. It took more than 100 years for this technology to gain widespread public use and yet 40 years later it is almost redundant.

And what of the common cold, the most frequent ailment of humankind, which results in billions of dollars worth of health care costs, over the counter remedies, and loss of productivity? The main causative agent, the human rhinovirus, was probably first recognised in the late 1950s⁷⁴ and yet 60 years on we still have no effective treatment. Curing the common cold has been one of medicine's most wished for and yet most elusive goals. Even today, despite deciphering the genetic code of all 99 known strains,⁷⁵ an effective cure-all treatment for the common cold is predicted to be unlikely.

71 J Thomas and S Ewing, The Digital Futures Report (part of the World Internet Project conducted by the ARC Centre of Creative Innovation (CCI)). At: <http://cci.edu.au/post/world-internet-project-finds-australia-still-a-nation-digitally-divided>

72 C Hawn (2009), 'Take two aspirin and tweet me in the morning: How Twitter, Facebook and other social media are reshaping health care, Health Affairs, Vol. 28.

73 G Andrews, Distance treatment of the girl next door. Are our therapy models flawed? Personal communication. July 2008.

74 The Medical Research Council Common Cold Research Unit. Ministry of Defence. <http://www.mod.uk/DefenceInternet/AboutDefence/WhatWeDo/HealthandSafety/PortonDownVolunteers/TheMedicalResearchCouncilCommonColdResearchUnit.htm>.

75 AC Palmenberg et al (2009), 'Sequencing and analyses of all known human rhinovirus genomes reveal structure and evolution, Science 3 April 2009, 324(5923): 55 – 59.

These examples serve to remind us that our health system needs to be robust enough to withstand unexpected and unknown changes in disease, technology, and society, as well as being agile enough to quickly assimilate new discoveries which may prevent illness, reduce suffering, and improve functioning. We cannot know, for sure, what is ahead of us, but there are already some signs of what may be in store for us down the track.

The environment in which we live may in future have an adverse effect on our health and wellbeing as the ambient temperature rises and climate variability worsens. Climate-related thermal stress, microbial proliferations, vector borne infections, impaired nutrition, and poverty are all possible consequences of the accumulation of greenhouse gases at the Earth's surface⁷⁶. On the other hand, greater awareness of the harm we are doing to our environment may encourage people to strive to live healthier lives, which are kinder to themselves and their surroundings.

The dramatic decline in infectious disease and the steady increase in diseases of the 'affluent', such as cancer, diabetes and heart disease, appear to be reliable trends for health planning purposes. However, as we are acutely aware, influenza pandemics and other infectious diseases such as HIV can suddenly arise and cause much suffering and ill health before a treatment can be found. Breakthroughs in research and technology may also considerably alter the prevalence of certain diseases and, therefore, radically change the way health resources are deployed. As an example, consider the development of a vaccine to prevent dementia or a treatment to mitigate its effects. It has been predicted that there will be a 200 per cent increase in the numbers of people with dementia over the next 30 years.⁷⁷ Such an innovation would dramatically reduce the need for a myriad of dementia related home and residential support services in the future.

Advances in medicine and technology have already markedly changed the landscape of health care delivery and are likely to continue to push the boundaries of diagnosis and treatment in the future.

Technological advances such as those identified in Figure 1.10 will require development of new skills (such as robotic surgery) and entail changes in the way health care services are delivered and, hence, workforce structures.

The mapping of the human genome, completed in 2003, opened up numerous avenues of research with the potential to identify health risk factors and personalise treatment depending upon an individual's genetic make-up. The field of 'personalised medicine' – the capacity to predict disease development and influence decisions about lifestyle choices or to tailor medical practice to an individual – holds enormous possibilities for the future.

“ The principle of adjusting treatment to specific patient characteristics ... has always been the goal of physicians. However, recent rapid advances in genomics and molecular biology are beginning to reveal a large number of possible new, genome-related, molecular markers for the presence of disease, susceptibility to disease, or differential response to treatment. Such markers can serve as the basis of new genomics-based diagnostic tests for identifying and/or confirming disease, assessing an individual's risk of disease, identifying patients who will benefit from particular interventions, or tailoring dosing regimens to individual variations in metabolic response. These new diagnostics can also pave the way for development of new therapeutics specifically targeted at the physiological consequences of the genetic defect(s) associated with a patient's disease.⁷⁸

76 AJ McMichael et al (2006), Climate change and human health: present and future risks, *Lancet*, 367:859-869.

77 J Goss (2008), Projection of Australian health care expenditure by disease, 2003 to 2033, Health and expenditure series Number 36, (AIHW: Canberra). Discussion paper commissioned by the National Health and Hospitals Reform Commission.

78 President's Council of Advisors on Science and Technology (2008), Priorities for Personalized Medicine. Executive Office of the President of the United States, September 2008.

Figure 1.10: Possible advances in medical technology

Rational drug design – computer search techniques could reduce the trial and error of random search for identifying likely drug candidates.

Pharmacogenomics – the use of molecular biology techniques to enable the creation of medicines that are personalised for an individual at a genetic level. This application has the potential to enhance effectiveness and tolerance of medicines and reduce adverse drug events.

Imaging and diagnostic advances – will likely expand the range of diseases that can be detected using imaging techniques (such as neuro-imaging as a biomarker of early Alzheimer's disease). Advances in miniaturisation of imaging devices could improve portability. There may be a reduced need for surgery to examine the structure and function of organs.

Telemedicine – allowing alternative 'remote' health care delivery options from health risk monitoring to intensivist supervision of emergency resuscitation or surgery.

Minimally invasive surgery, robotics and virtual surgery – particularly for neurological and coronary procedures.

Genetic testing, gene therapy and pharmacogenomics – testing could allow identification of genetic susceptibility to diseases and more effective, targeted use of pharmaceuticals (pharmacogenetics); gene therapy could correct the genetic cause of the disease rather than treating the symptoms.

New vaccines – could prevent cancers and may also offer less intrusive and costly ways to treat some cancers by stimulating patients' own immune systems.

Xenotransplantation and bioengineered organ, joint or tissue replacement – in theory, xenotransplantation (from non-human species) could provide an increased supply of organs for transplantation; biomaterials have been used to improve artificial joints; and there has been progress in creating more complex organs, such as artificial pancreases and artificial hearts.

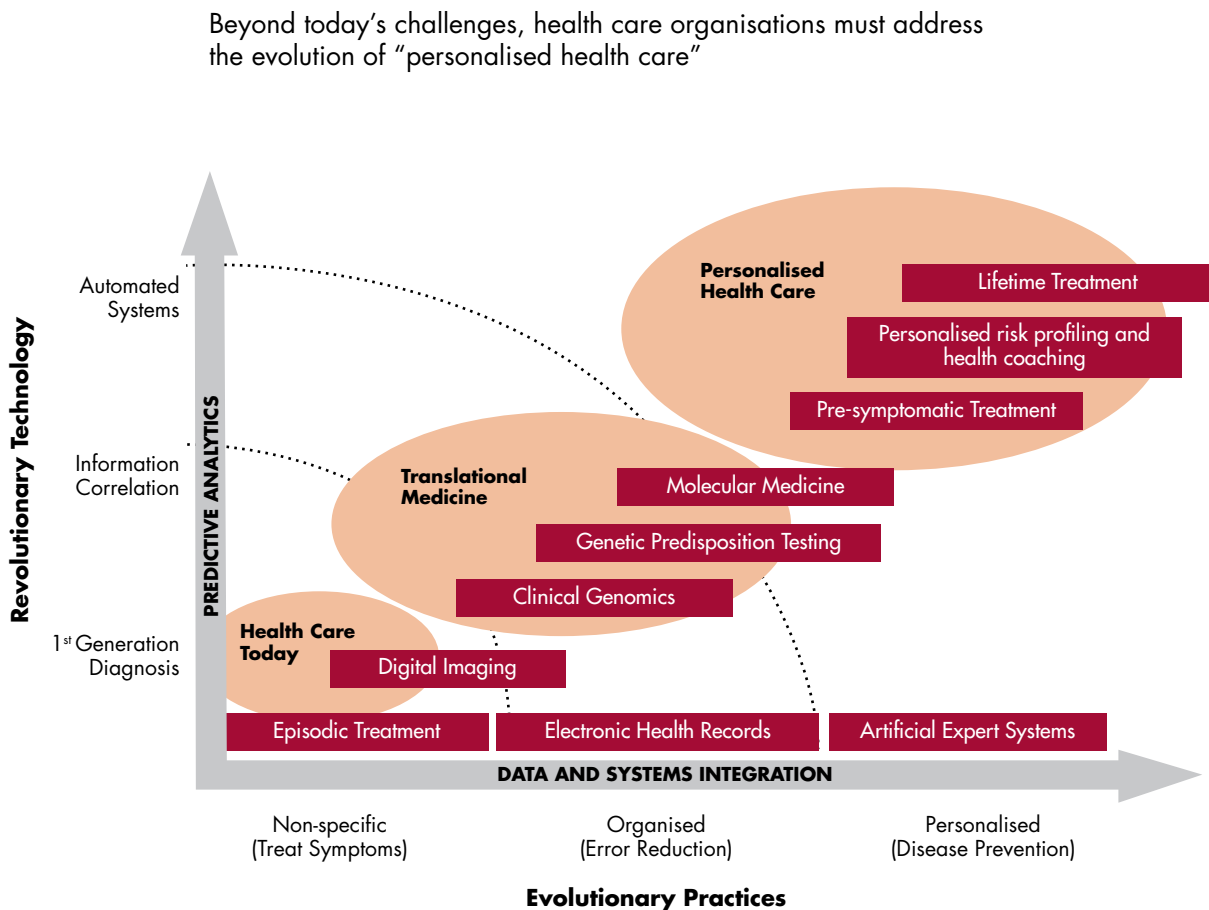
Stem cell therapies – could be based on adult or embryonic stem cells and possibly used to patch damaged hearts, restore pancreatic function in diabetes patients, and to treat patients with Parkinson's Disease.

Nanotechnologies and nanomedicine – involve the production and application of materials at an atomic scale. Nanodevices could deliver medicines directly to the site of the body in need and reduce required dosages.

Source: compiled from various: Productivity Commission 2005, Impacts of Advances in Medical Technology in Australia, Research Report, Melbourne; Discussion paper – Australia's Health 2018, R Head, Preventative Health Flagship, CSIRO; Medicines Australia (2008), Submission 456 to the National Health and Hospitals Reform Commission: First Round Submission.

As shown in Figure 1.11, the simultaneous evolution of data and analytical systems with advances in health and medical technology will create a powerful paradigm shift in clinical practice towards more personalised health care.

Figure 1.11: Evolution of personalised health care



Source: Adapted from IBM Health 2008 slide set.

This shift from a 'one size fits all' approach to a customised approach is likely to change the landscape of research and health care delivery but we can only guess at the pace and impact upon the burden of disease.

Among the possible implications of this field of medicine may be an enhanced capacity to:

- prevent disease by profiling individual risk and offer health coaching to better manage known risks;
- reduce adverse drug events and ineffective medication use via pharmacogenomics; and
- slow down the process of ageing.

To realise these possibilities, there will be an increasing need for more clinical geneticists and scientists to conduct genetic testing as well as increased research funding to translate genomic research into clinical practice.

1.6 Moving from complacency to action – the critical need for health system reform

1.6.1 A second tipping point

Over the past 16 months, we have been on a journey with the Australian community to develop a long-term reform plan for our health system. That journey has been nothing short of epic. Indeed, it was described by the Australian Medical Association upon our establishment as a ‘health trek...to go where no Commission has gone before’⁷⁹! We were not alone in our journey; other bodies have been commissioned to examine the future role and functioning of health promotion and illness prevention, primary care and maternity services within our health care system.⁸⁰ However, we have been tasked to look at the need for reform from an overall whole system perspective.

Experts in many areas gave us the benefit of their opinions along the way; health professionals working at the coalface patiently explained their concerns and aspirations; and organisations representing individuals, professions and various health sectors met with us and shared their vision for reform. Lastly, but equally as important, people from every walk of life shared their experiences and their ideas for ‘fixing’ the whole or parts of our health delivery system. This fact-finding mission suggested to us that there was an overwhelming sense that:

“ In every dimension and at every level, the Australian health system is not just fragmented, but atomised. Like iron filings scattered randomly on a piece of paper, its many players are influenced by different motivations, which in turn draw them in different, often opposing directions... More than ever, the Australian health system is in need of a magnet to align its efforts – strong, determined leadership fuelled by a bold, unifying vision.⁸¹

We received substantial feedback on our Interim Report which assisted us to refine our reform directions and formulate a cohesive approach to bringing these recommendations together into a plan of action. Many responded to specific reform directions and provided useful suggestions; others commented on the package of reforms and noted the need for a single, focused and overarching blueprint for reform⁸². Almost all encouraged us on the path of substantive health system reform:

“ The College would firstly like to convey its congratulations to the Commission for producing a report which puts Australia firmly on the path to true health reform. We would like to state our support for many of the initiatives proposed in the report, in particular the development of a National Health Promotion and Prevention Agency, Comprehensive Health Care Centres with enrolled populations, a commitment to ‘Closing the Gap’ in Indigenous health, the inclusion of school based health literacy education, and the commitment to the expansion of Specialist Outreach Services, which have particular impacts in our Indigenous and rural and remote communities.⁸³

79 Editorial (2008), ‘Big challenge for new Commissioners’, *Australian Medicine*, 20(5): 3.

80 Other groups included the Preventative Health Taskforce, the National Primary Health Care Strategy and the Maternity Services Review.

81 P Nicolarakis (2008), Submission 328 to the National Health and Hospitals Reform Commission: First Round Submissions.

82 For example: Parliament of Australia (2009), The interim report of the National Health and Hospitals Reform Commission – a summary and analysis, Research Paper.

83 Royal Australasian College of Physicians (2009), Submission 127 to the National Health and Hospitals Reform Commission: Second Round Submissions.

We have attempted to make sense of the vast array of concerns and problems brought to our attention, which affect the performance of our health care system. We have looked to other countries to compare and contrast problems and solutions. We have always looked to our people, our health professionals and industry experts to affirm our ideas and guide our recommendations.

Our conclusion – that there is an urgent need for substantive health system reform – aligns with many who have communicated with us along our journey. Our health system has reached a gateway, a second tipping point, beyond which the easy options have been exhausted and only the tough decisions remain. The door has shut on ‘point solutions’ and another opened to transformational change in the way we govern, fund and deliver health care services.

1.6.2 A moment in time for concerted action

The urgent need to resolve existing pressures, service gaps, safety concerns, inefficiencies and inequities, combined with emerging challenges, will lead to an increased but changed demand for health care and the need to achieve value-driven supply. Now is the time for action if we want to safeguard the health and wellbeing of future generations at an affordable cost to our nation.

All developed countries struggle to reconcile the implicit tension between three objectives: equitable access, high quality outcomes, and low cost. The trade-offs among these goals are inherently determined by social values and are played out through the political process. Evidence would suggest that an efficient health system can occur in a variety of forms and that the optimal structure is determined by social objectives⁸⁴. What balance should we have between public and private funding and provision of health services? Should all citizens contribute more in taxation to pay for health services in remote and rural areas if it will provide fairer access? What do we define as good quality health outputs and outcomes that we seek from our health system?

Some authors⁸⁵ have espoused the view that all health care systems around the world are becoming financially unsustainable due to a toxic combination of global forces including demographic changes, the increasing cost of medical technology, and an epidemiological shift towards more complex diseases. It has been suggested that governments have relatively few options and most will converge either haphazardly or methodically towards a common health care model.

What is important to remember is that there is no optimal level of expenditure on health services provided that society considers that, however measured, the benefits outweigh the costs⁸⁶. Therefore, the key is to ensuring that there is a clear objective measurement of the benefits and costs and that, in producing the health services, waste of resources and dollars is minimised.

Whether or not a common model unfolds internationally, there are clearly no simple one-step solutions such as higher government investment – we know that higher spending does not correlate with higher quality health care, nor better outcomes. Health care systems are notoriously resistant to reform in a large part because of the competing objectives of access, quality and cost. Vested interests and structural complexity bedevil attempts to ‘tweak’ the health system and nudge it in the right direction. Many proponents of health care reform tend to favour incremental adjustments but these rarely address the interdependency among seemingly autonomous actions and have unanticipated consequences. We need to move beyond point solutions and protection of vested interests if we are to maximise the health and wellbeing of current and future generations.

In the following chapters, we outline a comprehensive framework for health care reform which recognises the interdependencies of health care and takes action to shape incentives so that supply and demand find a socially acceptable equilibrium. We will describe an agile, self-improving, and sustainable health system which puts the health and wellbeing of people and families firmly at its centre.

84 J Richardson (2005), Priorities of health policy: cost shifting or population health, Australia and New Zealand Health Policy, 2(1).

85 J Anscombe, (2008), Health care out of balance. How global forces will reshape the health of nations. (A.T.Kearney, Inc).

86 J Richardson (2005), Priorities of health policy: cost shifting or population health, Australia and New Zealand Health Policy, 2(1).

CHAPTER 2

OUR VISION FOR LONG-TERM HEALTH REFORM



2. Our vision for long-term health reform

Creating a long-term health reform plan requires that we move from only thinking about ‘fixing’ the problems of today to designing a sustainable health system for the future. Imagining the future, and stepping outside of the ‘here and now’, is no easy task. It is much simpler to analyse and debate the merits of existing health services than it is to visualise and design a health system that meets the needs of future generations. In this chapter, we outline our vision for long-term health reform.

2.1 Driving health reform – everybody’s business

This Report is primarily intended to identify actions that can be taken by governments to reform the health system. However, we send a message that health reform is everybody’s business. To be sustainable, health reform must be driven at all levels of the health system and Australian society including:

- by individuals, carers and families;
- by local communities, advocacy groups and non-government organisations;
- by public and private hospitals, GPs, nurses, allied health practitioners, specialists, ambulatory and community health service providers;
- by health professionals, individually and collectively, including through learned colleges and professional associations and societies;
- by funders of health services including private health insurers, governments and other agencies;
- by universities, educational providers, research institutes and think-tanks;
- by employers, businesses and unions; and
- by all governments – the Commonwealth, state, territory and local governments.

Governments do not have a monopoly on health system reform, but they are uniquely able to influence the architecture of the health system and so create the imperative and support for others to act.⁸⁷ Actions taken by governments – such as new approaches to funding of health services – are often about allowing health professionals and health services to get on with the job of helping to create a better health system. Governments also have an important role in influencing how consumers can participate through investing in health literacy or strengthening consumer engagement mechanisms in the management of health services. But, of course, this works in both directions. To survive, governments must ultimately be responsive to the concerns of their constituents. This means that consumers, health services and other groups have an essential role in both identifying the case for change and creating the pressure on governments to take action on health system reform.

We want our Report to be a clarion *call* to action on health system reform by all parts of society, not just governments. As you read through the reform proposals, we want to encourage you to think about how *you* and *your* family, *your* community, *your* general practice, *your* hospital, *your* community health service, *your* workplace, *your* private health insurer, *your* university (and so on) can take actions to build a healthier future for all Australians.

2.2 Our vision and goals for health reform

Our vision is for a sustainable, high quality, responsive health system for all Australians, now and into the future.

To achieve this vision, we have developed a health reform plan that includes actions to improve health, structured under three reform goals, namely:

⁸⁷ Governments have an important role as ‘choice architects’. For further information, see: RH Thaler and CR Sunstein (2009), *Nudge: Improving decisions about health, wealth and happiness* (Penguin Group: Camberwell).

1. Acting to tackle major access and equity issues that affect health outcomes for people now (the health system of today);
2. Redesigning our health system so that it is better positioned to respond to emerging challenges (the health system of tomorrow); and
3. Creating an agile and self-improving health system for long-term sustainability (the health system of the future).

These three reform goals are not absolute and people may have legitimately different views as to how they classify particular health issues. Indeed, some health system issues will probably require a series of actions across all three fronts. This multi-level approach to reform is illustrated in Table 2.1 where we provide an example of how our recommendations across all three reform goals will result in better access to hospitals.

Framing reform around these three reform goals is important as it makes it clear that most of our efforts should be directed to 'redesign', and less to 'renovation' of the existing health system. (To use a loose analogy, it is not very productive to be debating the merits of VHS or Beta, when the paradigm has shifted to include Blu-ray and internet downloading of movies.)

We should also clarify that the three reform goals do not correspond to phases of reform that must be worked through sequentially. Action on major redesign of our health system and ensuring long-term sustainability has to start now, concurrently with tackling the most immediate access and equity issues.

Table 2.1: We need to take action at many levels to improve access to hospitals

Making sure that people can access hospital treatment when they need it involves improving how we organise and fund hospital services. But a health system is about much more than hospitals. Providing the right balance of services outside hospitals allows us to use hospitals more effectively when we really need them. Here is how some of our major recommendations will help people get the right care, including hospital care, more quickly.

Action to tackle major access and equity issues that affect health outcomes for people now

1. Public hospitals with major emergency departments will be built and funded so that they can keep some beds and staff readily available for emergencies. This means that patients who need to be admitted can be moved into a bed promptly; patients waiting in the emergency department can be treated within safe times; and the errors and poor outcomes associated with patients being seen in an over-crowded emergency department can be avoided.
2. National Access Targets will identify the maximum time in which people should be able to receive a range of health services, including planned surgery and emergency care in public hospitals.

Redesign of our health system

3. In public hospitals, patients scheduled for planned surgery may be cancelled because of emergency patients who need surgery more urgently. In the future, public hospitals will establish more stand-alone elective surgery services (with separate beds and staff than those used by patients admitted through the emergency department). This will allow both planned and emergency patients to get the right care at the right time.
4. New facilities will be built and staffed to provide rehabilitation services for people recovering after an operation (e.g. a hip replacement), an illness (e.g. a heart attack) or an injury (e.g. a car accident). Some people will be admitted to beds in these new 'sub-acute' facilities, but other people will be treated in ambulatory care settings. This will improve people's potential for recovery with less time spent in acute hospitals.
5. Some people visit emergency departments if they cannot get in to see their GP quickly enough or out-of-hours, or if they need access to multiple services (such as x-rays as well as medical treatment). New, larger Comprehensive Primary Health Care Centres and Services will be established to provide a 'one-stop shop' service. These centres will include (or organise access to) GPs, nurses, allied health services, pharmacy, x-ray and pathology services and specialist services and will be open on an extended hours basis.

6. *Better models of shared care will be developed across general practices, other primary health care services and specialist clinicians. This means that people who need care from many health professionals over time, such as maternity care, diabetes and cancer, are better able to manage their condition at home and avoid preventable visits to hospitals. This will be encouraged as the Commonwealth Government takes on responsibility for the public funding of primary health care and specialist services, whether provided in the community or through hospital outpatient clinics.*
7. *People with a chronic disease (such as diabetes or psychosis), young families and Aboriginal and Torres Strait Islander people will also be able to choose to register with a general practice or primary health care service. This will provide them with a 'health care home' with better coordinated care and access to an expanded range of health and community support services to meet their needs over time.*
8. *Greater choice in aged care services, better primary health and palliative care support and improved communication, advice and outreach to residential care facilities should reduce avoidable hospitalisations and enable more effective discharge to the best care environment for patients.*

Embedding agility and self-improvement

9. *Every Australian will be able to have an individual electronic personal health record. This will save time and make care safer when they use health services in different locations and across different health services (such as at a GP or specialist, hospital, or pharmacist).*
10. *Public hospitals will be funded for the number and complexity of the patients they treat and rewarded for performance indicators including access, effective communication and clinical outcomes. Greater public reporting on access, availability, safety and outcomes (such as clinical indicators and patient reported outcome measures) will assist informed decisions and choices of patients and their carers.*

2.3 Painting the picture – overview of our reforms

In our Interim Report, our proposals for change were crafted as 'reform directions'. This allowed consultation and valuable feedback on our proposals. As a result of this feedback, some of these proposals have been refined, some have stayed the same, and we have developed additional proposals in other areas.

Accordingly, our Final Report now includes 123 recommendations which comprise a long-term health reform plan, designed to achieve better health for all Australians and improve the performance of the health system. The complete listing of these recommendations is included at the end of our Executive Summary.

Table 2.2 provides an overview of our major recommendations for reform, grouped under the reform goals we described earlier. These are now described in more detail in Chapters 3–5.

Table 2.2: Overview of reform goals and actions

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

Table 2.2: Overview of reform goals and actions (continued)

- 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
 - Fostering quality, collaborative care through funding
 - Funding to better respond to people’s care needs over time
 - Driving efficiency and outcomes based purchasing
- Knowledge-led continuous improvement, innovation and research
 - Providing national leadership on quality care and knowledge management
 - Translating evolving knowledge into clinical practice
 - Enabling innovation and research system-wide

CHAPTER 3

TACKLING MAJOR ACCESS AND EQUITY ISSUES THAT AFFECT HEALTH OUTCOMES FOR PEOPLE NOW



3. Tackling major access and equity issues that affect health outcomes for people now

Ensuring that everybody can get access to effective and high quality health services is one of our most important priorities. Equity, or 'fairness' to use everyday language, is at the heart of the Australian health system, and is, indeed, a very strong part of the Australian social psyche. Many of our submissions were driven by a passionate advocacy of, and commitment to, improving access and equity in the Australian health system:

“ Ensuring that children have an equal start to life is recognised as a feature of a just and fair society, and is necessary for tackling health inequities in adulthood.⁸⁸

“ As a society, we are judged on how we treat our disempowered populations and people with mental illness are still significantly disadvantaged.⁸⁹

“ Unfortunately it is the most marginalised in our community who suffer the most from the failings of the current health system.⁹⁰

We strongly welcome the recent commitment by all Australian governments in the new National Health care Agreement that:

“ The health care system will strive to eliminate differences in health status of those groups currently experiencing poor health outcomes relative to the wider community.⁹¹

What we want to do is turn that aspirational principle into something real, measurable and achievable.⁹² To do this, we first start by putting forward our proposals for strengthening the universal basis of our health system. Next, we examine specific areas where the health care system is failing particular groups now, and present our recommendations to achieve better health outcomes for these people.

Finally, we canvass some changes that will build a real commitment to improving access and equity into our health system on an ongoing basis.

3.1 Refreshing our paradigm of universality

The concept of Medicare has always been grounded in 'access on the basis of health needs, not ability to pay'. But equity is about much more than whether health services are affordable. We know that the health system is not 'fair' and some people miss out because of where they live; others may experience a health system that does not meet their needs because of their different culture or language; and yet other people with a disability or a mix of complex health problems may find that there are major gaps in access to medical and other specialist services and the 'system' does not connect up all their care needs.

88 Public Health Association South Australia Branch (2008), Submission 150 to the National Health and Hospitals Reform Commission: First Round Submissions.

89 Monash University Alfred Psychiatry Research Centre (2008), Submission 419 to the National Health and Hospitals Reform Commission: First Round Submissions.

90 Catholic Health Australia (2008), Submission 57 to the National Health and Hospitals Reform Commission: First Round Submissions.

91 Council of Australian Governments (2008), National Health care Agreement, at: http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/IGA_FFR_ScheduleF_National_Health_care_Agreement.pdf

92 Appendices G and H provide further detail on the specific steps to implement each of the major reforms, who should be accountable, how much it will cost and when it should be delivered.

We believe that universalism is a vital platform for our health system. However, this does not mean that we should provide a 'one size fits all' model of health care. On the contrary, we are advocating that we need to refresh and strengthen our approach to universalism in two important ways:

- we want to translate *universal entitlement* into *universal access*. For example, we can't simply say that everyone has a universal entitlement to access to subsidised medical services under Medicare if people cannot realise that entitlement because there are no doctors in their community. We will provide some recommendations to tackle this problem for people living in rural Australia in Section 3.2.5; and
- we also want to improve on *universal access* (one size fits all) by proactively providing people with more complex needs with access to additional services (you get more if you need more). These additional services are 'universally' available to the population sub-group that needs them, but not to the whole population. We will give some practical examples of how this might work for young families when we explain our recommendations for promoting a healthy start to life in Section 4.1.3.

Together, these two changes represent an important shift in how we talk and act upon our commitment to universalism.

3.2 Acting now to improve equity in access and outcomes for people

When we examine health service gaps and inequities, it is apparent that sometimes the issue is about gaps, or difficulties in accessing, *particular services*. In this category, we have chosen to focus on three types of health services: dental care, public hospitals and crisis mental health services. Sometimes, however, the issue relates to *particular groups in the population* who face disadvantage across many or most health services compared with the general population. In this category, we will examine how to improve access and health outcomes for two specific populations: Aboriginal and Torres Strait Islanders, and people living in remote and rural Australia.

These are not necessarily the only services in short supply or the only populations that are underserved or have inequitable outcomes. But these gaps affect large numbers of Australians and result in substantial harm (poorer health status and higher rates of dying early) for many people.

Our recommendations on major system redesign in Chapter 4 will tackle some other important service gaps, but will do so through more fundamental system redesign in how we rebalance our investment to provide better connected services that take us from 'cradle to grave'. In particular, we noted in our Interim Report the stark health and access inequalities for the more than 300,000 people living with an intellectual disability. Many of our reform recommendations, such as voluntary enrolment with a primary health care service as their 'health care home' and the broad purview of health promotion and prevention, will assist. Access to specialist medical services is also a major gap to be addressed for people living with an intellectual disability.

For each of the major service gaps and inequities identified above, we now explain how the system fails people and outline our recommendations to improve care and outcomes for these people.

3.2.1 Dental health services

The gaps in dental health services are painfully obvious, particularly to the 650,000 plus people on public dental waiting lists. We know that nearly one third (31.2 per cent) of all Australian adults avoided or delayed visiting the dentist due to costs.⁹³ Little wonder, given how expensive it is to pay for dental care. The average household who used dental services spent 3.1 per cent of their weekly

93 J Spencer and J Harford (2008), Improving oral health and dental care for Australians, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

budget – almost \$30 per week – on dental care.⁹⁴ People are making choices about whether to get their teeth fixed, or pay their gas and electricity bills (3.8 per cent of weekly household spending), or meet their children's education costs (3.7 per cent of weekly household spending).⁹⁵ Our lack of access to affordable dental health services means that Australia ranks among the bottom third of OECD countries for rates of dental decay among adults.⁹⁶

And if that isn't bad enough, we are witness to the worsening dental health of our children. While experts might debate the factors (such as sugary drinks) that contribute to the recent 20 per cent increase in tooth decay among children⁹⁷, it cannot help that cutbacks to school dental services mean that fewer children can get access to these services.⁹⁸ At the other end of the population, poor access to dental care can have a major impact on the health and social functioning of older people⁹⁹ and is contributing to problems with malnutrition in some older, frail people.

We want to state loudly and clearly that it is inexcusable in a relatively wealthy country such as Australia (even in a global financial crisis) that we do not ensure universal access to effective, basic dental health services.

We want a health system with teeth.

Our proposal to create **a new universal scheme for access to basic dental services – 'Denticare Australia'** – was one of the most welcomed, and talked about, ideas coming out of our Interim Report. From the letters pages of daily newspapers to conversations around office water coolers (fluoridated, we hope), there was widespread support for improving access to dental services.

But just how do we move to providing universal access to dental services? Our Interim Report has generated a healthy debate about the different routes to get there and, for that, we do not apologise. (We do want to stand back from the current debate about the relative merits of various incremental approaches to improving access to dental services such as the Commonwealth Dental Health Program and the Medicare Enhanced Primary Care scheme).

First, we have to determine how to raise the funding required to meet the extra costs of providing universal access to basic dental services. We have suggested that this could occur through raising the Medicare Levy by 0.75 per cent of taxable income. Although tax increases may not be popular, opinion polls consistently show that Australians are prepared to support higher taxes (or the redirection of spending from other areas) to get better access to health services.¹⁰⁰

Second, we have developed an innovative approach to how we pay for dental services. It is not the same as including dental services on the Medicare Benefits Schedule and we need to explain why that is the case.

Under Denticare Australia, everyone would have the choice of getting dental services paid for by Denticare Australia, either through a private health insurance plan or through public dental services. In some cases, public dental health services may contract with private dentists. The services covered under Denticare Australia would include prevention (such as scale and cleaning of teeth), restoration (such as fillings), and the provision of dentures.

About 45 per cent of Australians already have private health insurance for dental care. These people would not pay twice under Denticare Australia. Instead, people who want to take out insurance for the

94 National Centre for Social and Economic Modelling (2008), Distribution of expenditure on health goods and services by Australian households. Discussion paper commissioned by the National Health and Hospitals Reform Commission.

95 National Centre for Social and Economic Modelling (2008), Distribution of expenditure on health goods and services by Australian households. Discussion paper commissioned by the National Health and Hospitals Reform Commission.

96 J Spencer (2001), What options do we have for organizing, providing and funding better public dental care? Australian Health Policy Institute, Commissioned Paper Series 2001/02.

97 J Spencer and J Harford (2008), Improving oral health and dental care for Australians, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

98 J Spencer and J Harford (2008), Improving oral health and dental care for Australians, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

99 Australian Dental Association (2008), Submission 324 to the National Health and Hospitals Reform Commission: First Round Submissions.

100 Research Australia (2005), Health and medical research public opinion poll 2005, at: http://researchaustralia.org/content/documents/RA_POP05_LowRes.pdf

universal package of basic dental services would have their premiums paid for by Denticare Australia. (People would still have the option to take out health insurance for additional dental services (such as orthodontics)). Or Denticare Australia would pay the costs for people using public dental services.

The report we commissioned on the costing of Denticare Australia¹⁰¹ indicates that many people will pay no more than they currently pay for dental care. Many people on low incomes will pay considerably less and have much better access to dental health services. While higher income people may pay more through the increased Medicare Levy compared to their existing premiums for private dental insurance, some of these people will face smaller out-of-pocket costs for dental care under Denticare Australia.

We are recommending this new approach for several reasons. First, it gives people who are already insured the choice of continuing to get their dental services from private dentists as now. We know that almost half the population has private insurance for dental services and that 83 per cent of dentists are employed in the private sector.¹⁰² So it makes sense to build on this predominantly private approach to delivering and paying for dental services, rather than building a new Dental Benefits Schedule in Medicare.

However, we are combining this largely private provision model with new public funding raised through the Medicare Levy to get the best of both worlds. By raising the funding for universal dental services through the Medicare Levy, we are introducing greater fairness linked to ability to pay. Everyone – not just people who are currently insured – will be able to have a private dental plan or use public dental services to access the same universal package of basic dental services. Denticare Australia would pay in both cases. The difference will be that people who choose the private dental plan will probably be required to make a small co-payment (much less than is now the case) in using dental services, while publicly insured people will not have a co-payment but will probably have to wait for some services (again, much less than is now the case).

We expect that private insurance may pay for some care provided in the public dental sector (as public dental services tend to treat some of the most complex patients such as people with an intellectual disability). Similarly, public dental services may purchase some services from private dentists under contract to supplement their network of services. Waiting times for public dental services will be reduced, as Denticare Australia will fund public dental services on the basis of the number of publicly insured people.

We know that providing universal access to basic dental services will require a significant expansion of the public oral health workforce.

Hence we have recommended **internships for graduating dentists and oral health professionals** – these will be important in expanding the public dental workforce, as well as providing broader clinical experience and training. This will require an investment to provide the facilities, equipment and supervision for these graduates. Finally, we support the adoption of a nationally consistent approach to the best use of all oral health professionals (including, for example, dental therapists and hygienists).

3.2.2 Timely access to quality care in public hospitals

In Table 2.1 we highlighted that many of the reforms required to improve access and quality of care in hospitals involve major redesign of our whole health system. Improving access to primary health care services (such as GPs, nurse practitioners and allied health services), helping people recover after an operation in new sub-acute facilities, and supporting people with a chronic illness to live independently in the community are all essential if we want 'to let hospitals be hospitals'. These changes will strengthen hospitals and position them as flagship institutions for caring for those with complex care needs, for research, education and training, and for innovation.

101 PriceWaterhouseCoopers (2008), Costing a social insurance scheme for dental care, at: www.nhhrc.org.au

102 J Spencer and J Harford (2008), Improving oral health and dental care for Australians, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

However, we also need to take action now to improve timely access and quality of care in public hospitals. Two priorities are care in **emergency departments** and **elective surgery waiting lists**.

We know that about seven per cent of people who visit a major public hospital **emergency department** will give up on waiting and leave the emergency department.¹⁰³ While these are more likely to be people with less urgent health problems, sometimes people are not the best judge of how serious their illness is and leave prematurely. And for the people who wait and are treated in emergency departments, there is evidence that over-crowded emergency departments can lead to poor outcomes. A paper prepared by the Australasian College of Emergency Medicine claimed that there may be about 1,500 deaths each year that directly result from overcrowding in public hospital emergency departments.¹⁰⁴ An important contributing factor to overcrowding and 'access block' is not being able to admit patients from the emergency department to a hospital bed promptly when they need it.

This is why we have recommended that public hospitals with major emergency departments be funded to ensure beds are available at all times for people needing to be admitted from the emergency department. Currently, what happens is that some major hospitals may be operating at close to, or even over, 100 per cent occupancy. (Operating at over 100 per cent occupancy does not mean two patients to a bed, but it may mean patients waiting on trolleys in corridors to get into a bed). Our proposal involves building and funding major public hospitals with emergency departments so that they operate at closer to 85 per cent occupancy. This would allow public hospitals to have 'spare' or 'stand-by' bed capacity and on-call staff available. For patients, this would mean quicker access to a hospital bed if it is needed in an emergency and less crowded emergency departments with care being provided more quickly and safely.

Turning to **public hospital waiting lists**, we know that some patients may wait for an extended time for so-called 'elective' surgery, such as a hip replacement and for medical treatments, such as radiotherapy. (We should clarify that the term 'elective' does not mean that the surgery or procedure is not essential; rather, it is used to refer to the situation where the clinician has determined that the surgery or procedure can be safely delayed for at least 24 hours and it is therefore not regarded as an 'emergency' admission). Currently public hospital waiting lists measure the length of time people wait for elective surgery, but they do not routinely measure the time that people wait to get an outpatient visit (in order to be put on a waiting list for elective surgery), nor do they necessarily measure waiting time for various medical procedures (such as diagnostic scans or radiotherapy).

Waiting times for elective surgery have increased over the last few years. The most recent published data indicates that the median¹⁰⁵ waiting time across all types of elective surgery was 34 days in 2007-08, up from 28 days in 2003-04. Since this time, additional funding of \$150 million was provided by the Commonwealth Government to allow states and territories to treat about 25,000 extra patients in 2008. In March 2009, health ministers announced that states had exceeded this target, treating an extra 41,000 patients in 2008.¹⁰⁶ (We note that it is too early to assess the extent to which the treatment of extra patients has resulted in measurably shorter waiting times for patients).

We are recommending that **National Access Targets** be developed and adopted to assess the timeliness of care across all health services, including public hospital services (Section 3.3 provides further detail). In regard to National Access Targets for elective surgery, we note that the Commonwealth Government has already committed \$150 million annually up until 2010-2011 to reduce waiting lists. Our proposal to tackle elective surgery waiting times is based on extending this additional funding beyond 2010-2011, plus providing extra funding to meet the anticipated higher demand for elective surgery as existing waiting lists are cleared.

In addition, we believe that it is important to separate out the provision of planned surgery and emergency care. We are recommending (see Section 4.2.2) that there be more provision of dedicated facilities for planned surgery, either within an existing hospital or in separate, stand-alone facilities

103 Department of Health and Ageing (2008), The state of our public hospitals: June 2008 report (Commonwealth Government: Canberra).

104 R Forero and K Hillman (2008), 'Access block and overcrowding: a literature review', Prepared for the Australasian College of Emergency Medicine.

105 The median waiting time means that 50 per cent of people will be treated in less than this time and 50 per cent of people will wait longer than this time.

106 Australian Health Ministers' Conference (2009), Communique, 5 March 2009, at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/DEE44E7131D32A16CA25757000168908/\\$File/AHMCcommunique050309.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/DEE44E7131D32A16CA25757000168908/$File/AHMCcommunique050309.pdf)

to increase the efficiency of these services and to overcome the problem of elective surgery being cancelled when emergency patients are given a higher priority.

3.2.3 Crisis mental health services

Mental health problems are much more common than many people realise – over one in ten people report that they have a long-term mental or behavioural problem.¹⁰⁷ Our recommendations on strengthening primary health care and better integrating primary health care, specialists and acute hospital care (see Section 4.2.1) are intended to provide the platform for more effectively responding to some of the high prevalence mental health disorders, such as depression.

In this section, we have focused on improving care for people with (or at risk of) serious mental illness. About three per cent of the population may be severely disabled due to mental disorders such as psychosis, bipolar disorder, or severe depression or anxiety.¹⁰⁸

Getting the right support and care services for people with severe mental illness involves some fundamental changes to how we organise care. We set out ways to ensure there is a range of treatment and support services connected across the spectrum of care. A key element is our recommendation to expand sub-acute services in the community. We will explain our recommendations for redesign of mental health services in more detail in Section 4.2.2.

While the focus should be on early intervention and better management of mental health disorders, we also recognise the need to provide the right types of services when people experience a crisis such as an acute psychotic episode. The tragedy of suicides and preventable violence, coupled with police often being used as de facto first responders to people suffering a mental health crisis, demands a better response. We also know that busy emergency departments are often the worst place for someone experiencing psychosis, yet this becomes the default setting.

Accordingly, we are recommending that all acute mental health services have a **‘rapid response outreach team’** (known in some states as crisis and assessment teams). These teams must be available 24 hours a day to urgently assess a person experiencing a mental health crisis and provide required short-term treatment, before the person is connected back in with ongoing management and support. (Attention will need to be given to ensuring the safety of team members through collaboratively working with law enforcement agencies.) While some rapid response teams may be located in acute hospitals, they should provide a true ‘outreach’ service, going out to the person, rather than relying on the person necessarily always being brought into the emergency department. Rapid response teams can provide intensive community treatment and support, often in the person’s home, as an alternative to hospital-based treatment. We believe this vital service needs to be available nationally.

3.2.4 Aboriginal and Torres Strait Islander health

The challenges and health problems facing Aboriginal and Torres Strait Islander people have been documented with frightening regularity for decades. Significantly reduced life expectancy, high maternal and infant rates of mortality and morbidity, low birth weight babies, Third-World rates of infectious diseases, unacceptable levels of diabetes and kidney disease (and consequent need for dialysis), generational problems of alcohol and drug abuse and violence, the list goes on...

Trying to do justice to right the systemic disadvantage facing Aboriginal and Torres Strait Islander peoples is beyond the scope of our Commission. We support the need for a multi-faceted strategy and, indeed, the Council of Australian Governments has endorsed an approach to Close the Gap targeted towards seven building blocks: early childhood, schooling, health, economic participation, healthy homes, safe communities, and governance and leadership.¹⁰⁹

¹⁰⁷ Australian Institute of Health and Welfare (2007), *Mental health services in Australia 2004-05* (Australian Institute of Health and Welfare: Canberra).

¹⁰⁸ The Boston Consulting Group (2006), *Improving mental health outcomes in Victoria: the next wave of reform*.

¹⁰⁹ Council of Australian Governments (2008), *National Indigenous reform agreement*, at: http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/IGA_FFR_ScheduleF_National_Indigenous_Reform_Agreement.pdf

Our response has been strongly shaped by several important factors including:

- we acknowledge that health is a fundamental human right. Ensuring that we can improve health outcomes for Aboriginal and Torres Strait Islander people is essential to basic human dignity;
- any solutions must be 'owned' by, and acceptable to, Aboriginal and Torres Strait Islander people. We have welcomed the engagement of key groups including the Close the Gap Steering Committee for Indigenous Health Equality, the National Aboriginal and Community Controlled Health Organisation and a range of Aboriginal and Torres Strait Islander health professional organisations in helping to shape our ideas and in providing feedback on the proposals in our Interim Report; and
- tackling health service gaps and inequities has to cut across metropolitan and rural communities, and involve both Aboriginal Community Controlled Health Services and mainstream health services. Contrary to popular opinion, the majority (53 per cent) of Aboriginal and Torres Strait Islander people live in a major city or inner regional centre, with only 25 per cent living in remote parts of our country.¹¹⁰ Both mainstream and Aboriginal Community Controlled Health Services are important sources of care,¹¹¹ so we need to tackle improvements in access and quality across all health services.

How do we get the right services and outcomes for Aboriginal and Torres Strait Islander people?

We are recommending a radical change to how we take responsibility for improving the health of Aboriginal and Torres Strait Islander people. We want all the funding that is (and should) be spent on Aboriginal and Torres Strait Islander people to be aggregated. We want **a new National Aboriginal and Torres Strait Islander Health Authority** (NATSIHA) to take this funding and actively purchase and commission the very best health services – effective, high quality, culturally appropriate and meeting the needs of Aboriginal and Torres Strait Islander people, their families and their communities. And we want this Authority to demand and hold all health services accountable for providing the right services for Aboriginal and Torres Strait Islander people. This also means that we need to invest more than we do now, so that the Authority can ensure that spending actually matches the greater health needs of Aboriginal and Torres Strait Islander people.

This is similar to what the Department of Veterans' Affairs (DVA) does now to make sure that our veterans get the best possible care. It sets explicit standards for the quality of care. It contracts with whichever health services – public, private, hospitals, GPs, primary health care services – can deliver against these standards. And it consistently listens and learns from the experience of veterans in how to do better. We believe that a similar strategy should be used to close the gap for Aboriginal and Torres Strait Islander people. This goes beyond simply providing access to ensuring the achievement of quality outcomes.

This is a huge change. It is a dramatic shift from 'business as usual'. It is driven by a philosophy that says we must, first, invest at the right level, and, second, guarantee that this investment produces the best outcomes for Aboriginal and Torres Strait Islander people. This is *not* about the creation of a 'separate' health system for Aboriginal and Torres Strait Islander people. It is about *all* health services providing the right care and helping to close the gap.

That is the vision. Now for some more detail. We are recommending that this new Authority sit within the health portfolio. We want it to be staffed with people who are expert in purchasing health services. (To separate out this purchasing role from other functions such as provision, program development and advocacy, the Authority should be separate from the Office of Aboriginal and Torres Strait Islander Health). There also needs to be a genuine commitment to partnership and working collaboratively with Aboriginal and Torres Strait Islander people, both by the new Authority and across the Commonwealth health portfolio generally.

110 Australian Bureau of Statistics (2008), Population characteristics, Aboriginal and Torres Strait Islander Australians, 2006, Cat. No. 4713.0, (Australian Bureau of Statistics: Canberra).

111 In our Interim Report we used data from the Australian Bureau of Statistics that suggested that 70 per cent of Aboriginal and Torres Strait Islander people used mainstream health services and 30 per cent used Aboriginal medical services. Subsequently, the Close the Gap Steering Committee for Indigenous Health Equality and the National Aboriginal and Community Controlled Health Organisation have provided us with advice from other surveys of health service use that suggest that Aboriginal medical services provide a much greater share of care – potentially between 50-60 per cent of all care received by Aboriginal and Torres Strait Islander people. None of the existing surveys and databases is conclusive – due to the problems of under-reporting of Aboriginal and Torres Strait Islander status and the complexity in capturing service use across the full spectrum of primary health care, hospitals and other specialist services. The fact that we actually have such poor data on the types of services used by Aboriginal and Torres Strait Islander people is, itself, an indictment and one that needs to be remedied. For further information on this issue, see: Close the Gap Steering Committee for Indigenous Health Equality (2009), Submission 120 to the National Health and Hospitals Reform Commission: Second Round Submissions.

While this proposal represents a major change, we have been encouraged by the growing interest in, and broad endorsement of, the concept by some key groups following our consultations after the release of the Interim Report. The Close the Gap Steering Committee for Indigenous Health Equality has indicated that it believes that:

“ The proposed National Aboriginal and Torres Strait Islander Health Authority could support the achievement of Indigenous health equality by 2030 if for no other reason than its establishment may catalyse a cultural shift within the health system to support a genuine partnership between government and Indigenous peoples and their representatives... This not only reflects the human rights of Indigenous peoples, but is also common sense from a policy perspective.¹¹²

We also believe that other important reforms at the service delivery level are required to complement the Authority's role of expert purchasing and commissioning for better outcomes. Some of these comprise part of our broad package of health reforms for the whole Australian community. The strengthening of primary health care services, a healthy start to life and universal access to basic dental services are all essential if we are serious about improving outcomes for Aboriginal and Torres Strait Islander people.

In our Interim Report, we proposed that young families and people with chronic and complex conditions (including people with a disability or long-term mental illness) have the choice of 'enrolling' with a single primary health care service so that their health needs could be better coordinated and they could get access to an expanded range of services. We have decided to broaden this so that all **Aboriginal and Torres Strait Islander people would be eligible to enrol with a primary health care service** (not just those with young families or chronic and complex conditions). We expect that, for many, this would continue to be their Aboriginal Medical Service from which they already receive most of their health service needs.

Since the release of our Interim Report, we have commissioned further research on the use of primary medical services by Aboriginal and Torres Strait Islander people.¹¹³ One significant finding was that young children had the poorest access to primary medical services, relative to the rest of the Australian population. Use of primary medical services was significantly lower for Aboriginal and Torres Strait Islander children up to age 14, with the worst access being for children under five years of age. Enrolment of families with young children, together with a new focus on a healthy start to life, are vital to redressing this major deficit in the lives of Aboriginal and Torres Strait Islander children.

A key element of a healthy start to life is about good nutrition and a healthy diet. Five per cent of the total health gap among Aboriginal and Torres Strait Islander people is due to low fruit and vegetable intake.¹¹⁴ Yet, we know that the tyranny of distance translates into high transport costs and leads to grossly inflated prices for fresh foods in some remote Aboriginal and Torres Strait Islander communities. Accordingly, we are recommending an integrated package to **improve affordability of fresh food, fruit and vegetables in targeted remote communities**. This package would include subsidies to bring the price of fresh food in line with large urban and regional centres, investment in nutrition education and community projects, and food and nutrient supplementation for schoolchildren, infants, pregnant and breastfeeding women (such as folate for pregnant women, free fruit for children). This strategy should be developed in consultation with Aboriginal and Torres Strait Islander communities, building on some of the successful work already underway.

112 Close the Gap Steering Committee for Indigenous Health Equality (2009), Submission 120 to the National Health and Hospitals Reform Commission: Second Round Submissions.

113 J Deeble (2009), Assessing the health service use of Aboriginal and Torres Strait Islander people, Background paper commissioned by the National Health and Hospitals Reform Commission.

114 T Vos, B Barker, I Stanley and AD Lopez (2007), The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003, (University of Queensland School of Population Health: Brisbane).

Finally, we must **strengthen the vital role of Community Controlled Health Services, train and recognise an Aboriginal and Torres Strait Islander health workforce and a workforce for Aboriginal and Torres Strait Islander health**, and up-skill our health workforce to provide culturally appropriate services. This includes a requirement to comprehensively recruit, retain and train Aboriginal and Torres Strait Islander health professionals at the undergraduate and postgraduate levels.

3.2.5 Remote and rural health

The picture of health care in the bush is a mixed one. We know that there has been a loss of maternity services in many country towns, forcing women to make difficult choices about where, and when to leave home, to give birth.¹¹⁵ We also heard many stories of ‘cancer commuters’ – country people sometimes travelling hundreds of kilometres several times a week for months on end to receive chemotherapy or radiotherapy in large city hospitals. But we also know that remote and rural communities have often been the ‘incubators of innovation’¹¹⁶ when it comes to providing creative solutions to health care.

Our recommendations are directed at tackling the gap between having a universal *entitlement* under Medicare and not getting this universal access to services due to the limited availability of doctors in remote and rural communities.

Changing the way funding works is the first critical step. We are proposing that **under-served remote and rural communities be given a ‘top-up’ or equivalent amount of funding on a per capita basis**¹¹⁷ as communities with better access to medical, pharmaceutical and other primary health care services. This would be adjusted for the costs associated with remoteness and health needs of these populations. The MBS and PBS would still apply in these communities, but they would receive a ‘top up’ equivalence payment to bring their spending to average levels. This approach would empower remote and rural communities who could identify the best mix of services required to meet their specific needs, courtesy of access to an equitable amount of funding. It would unleash rural creativity and represent a significant reduction in red tape associated with writing submissions for the uncoordinated mish-mash of rural health programs currently on offer. Governments would still need to work with such communities, potentially through the Primary Health Care Organisations (see Section 4.2.1) to ensure that health services are planned at a regional level, rather than developing solutions for local towns in isolation from one another.

We also strongly support **increased funding for patient travel and accommodation** for patients and their families on a nationally consistent basis. Patient travel and accommodation is an essential requirement of guaranteeing access to health services for many country patients and should be funded as such. The accommodation or travel expenses allowance you receive should not vary according to which state or territory you live in. This is one important aspect of all Australians having equal access to ‘one health system’.

Since the release of our Interim Report, we have given further consideration to the issue of the maldistribution of the health workforce. We know that some rural and remote communities face an uphill battle in recruiting and retaining many types of health professionals, including doctors. Rural Health Workforce Australia has described this as a chronic problem that cannot be absolutely ‘fixed’, but instead requires constant and sustained attention to evolving strategies that shift and adapt to changed circumstances.¹¹⁸

We believe that a new energy is required to reinvigorate the debate about **an integrated package of strategies to improve the distribution of the health workforce**. The new national health workforce agency (see Section 5.2.2) could lead this development, working in partnership with rural workforce agencies, universities, the vocational education and training sector, specialist colleges, health professional associations and health service providers. A useful principle is that all elements of an integrated package to tackle the maldistribution of the health workforce should apply across all

¹¹⁵ National Rural Health Alliance (2008), Submission 333 to the National Health and Hospitals Reform Commission, First Round Submissions.

¹¹⁶ John Wakeman and John Humphreys (2009), Submission 146 to the National Health and Hospitals Reform Commission, Second Round Submissions.

¹¹⁷ Funding would also be adjusted to reflect other factors such as higher costs of service provision in rural and remote communities or different health needs.

¹¹⁸ Rural Health Workforce Australia (2009), Submission 108 to the National Health and Hospitals Reform Commission, Second Round Submissions.

health professionals. Without limiting the scope of this reform package, examples of potential support mechanisms might include: university fee relief, periodic study leave, locum support, extension of medical bonded scholarships, and extension of the model to all health professions. Specialty colleges could also provide support through providing preferential access for remote and rural practitioners to training based on recognising related prior learning, clinical experience and work opportunities of remote and rural practitioners. Finally, we are recommending greater investment in **a remote and rural health research program** in order to build health service, clinical and workforce capability.

The proposals we have described above to improve access in remote and rural communities are only part of the solution. We cannot, and should not, be simply developing rural-specific 'point' solutions. That is why our rural recommendations need to be read with our other proposals on evolving Medicare, creating a stronger primary health care platform, and training and flexibly funding a 21st century health workforce.

3.3 Creating robust commitments to ongoing improvements in access – National Access Targets

To date, we have discussed some of the most significant access and equity issues that affect health outcomes for people now – either relating to particular services or impacting on specific population groups.

We believe that we need an ongoing way in which we can continuously measure and report on whether people are getting access to the health services they need. (Access is one important dimension of whether our health system is performing well.)

In our Interim Report, we proposed developing and using National Access Guarantees and Targets to measure the performance of hospitals. Based on further deliberation, we have refined this initial concept and we are now recommending the development of National Access Targets across the whole continuum of health services. Our rationale and development of this recommendation is as follows:

- current performance measures are weighted heavily, or almost exclusively, on public hospitals. This does not recognise that people have equally important needs to access other types of services such as general practitioners, mental health services or family and child health services. We want to ensure that access measures do not distort the allocation of resources. If we only set National Access Targets for one part of the health system, it is likely that funding (and media interest) will focus on that one issue to the detriment of other important health services;
- in thinking about access to health services, we need to recognise that health needs and use of health services form part of a continuous 'episode of care'. Often, we only measure and value access at the 'acute' end of the episode of care, but access earlier in the episode of care can be equally important in improving health outcomes for people. For example, if we think about cancer, a balanced approach might include measuring access to:
 - risk reduction interventions (such as smoking cessation programs);
 - preventive interventions (such as the provision of the cervical cancer vaccine);
 - cancer screening services (such as mammograms);
 - diagnostic visits and tests (such as GP, private specialist and hospital outpatient consultations, magnetic resonance imaging);
 - treatment interventions (such as cancer surgery, radiation oncology and chemotherapy); and
 - palliative care (such as hospices, respite care, community nursing).

If we consider the whole 'episode of care', that also means that it might be preferable to measure access, or waiting, from start to finish, rather than focusing on only one element of the care continuum;

- we also must weigh the need to take a balanced approach to measuring access to a broad range of health services with an equally important objective of not creating excessive 'red tape' for health service providers. This means that we should identify a small number of high value National Access Targets, not create a multiplicity of measures that take health professionals away from patients; and
- we believe it is important to first develop and test the use of National Access Targets, before moving to implementation of National Access Guarantees. Some 'targets' may evolve into 'guarantees' as long as we can ensure that this does not distort how funds are allocated across the health system. Further work will be required about how to give effect to a guarantee in the health system. For example, a guarantee could be interpreted to mean that a person is given a voucher to access the same service elsewhere if the recommended access times are not met for that service. Implementing such an approach would involve significant changes to how health services are currently funded and implies that 'substitute' services are available, which may not always be the case. Our current proposal is that National Access Targets be given effect through the payment of 'bonuses' to health services that meet the targets. Achieving this will, in itself, require substantial work if we hold true to setting National Access Targets across a wide spectrum of health services, rather than just hospitals.

We want National Access Targets to be developed through broad consultation involving the community and incorporating clinical, managerial and financial perspectives. Different groups will have different values and priorities about the range of health services which should be measured against new National Access Targets.

To set the ball rolling and to demonstrate leadership on this issue, we are proposing a preliminary set of National Access Targets (see Table 3.1).

Table 3.1 illustrates both the breadth of health service domains that we believe should be included in National Access Targets and actual measures of access. Our views on progressing this preliminary set of National Access Targets are as follows:

- we would expect that these targets would be the subject of broad and extensive consultation and further refinement before their implementation. It is critical that we get real community engagement on what is valued and the priority we should give to measuring access to different types of health services;
- national Access Targets should not be cast in stone, but should evolve over time. This should occur in response to both changing community priorities and to improvements in performance in some health service domains (this means that we can move on to measuring and improving performance in other domains); and
- we know that the need for health care does not fall evenly across the whole population. This means that we should also measure access for specific groups in the population (Aboriginal and Torres Strait Islander people, residents of remote and rural Australia etc) who may have different needs than the 'average' person in the population.

Table 3.1: Preliminary set of National Access Targets

This set of National Access Targets identifies the maximum time¹¹⁹ in which patients should be able to receive access. Depending upon the urgency of their needs, some patients may require treatment much more rapidly. National Access Targets should be used in association with the development of robust triage and urgency classifications¹²⁰ so that health professionals can make decisions based on the particular needs of individual patients.

Primary health care services: no more than 1 day to access a primary health care professional; no more than 2 days to access a medical practitioner

Health telephone support (National Health Call Centre Network): no more than 10 minutes to receive initial telephone advice

Postnatal care: home visit to a new mother within 2 weeks of giving birth

Crisis mental health services: response within 1 hour for emergency patients and within 12 hours for priority patients

Community mental health services: contact within 7 days of discharge from an acute mental health service for patients with psychosis, or within 1 month following referral for other patients

Drug and alcohol treatment program: within 1 month following referral

Aged care assessment: assessment within 48 hours for patients requiring immediate response, or 14 days for patients whose condition is deteriorating

Public hospital outpatient services: within 2 weeks for first appointment for urgent patients with a life-threatening condition and within 3 months for other patients

Radiotherapy: within 1 day for emergency care patients, 2 weeks for high priority patients and 1 month for other patients from referral to commencement of therapy

Planned surgery: 1 month for high priority (Category 1) patients and 3 months for priority (Category 2) patients

Ambulance services: 15 minutes for potentially life-threatening events in metropolitan areas

Emergency departments: immediately for resuscitation (Category 1) patients, within 10 minutes for emergency (Category 2) patients, within 30 minutes for urgent (Category 3) patients

119 For simplicity, we have set these targets on the assumption that all people (100 per cent) of the population should get access within these times. However, some of these measures are now reported using the median (the time in which 50 per cent of the population can expect to receive access) or the 90th or 95th percentile. A percentile approach builds in an escalator to 'ratchet-up' performance over time. However, this performance improvement approach needs to be balanced with a system that is transparent and able to be readily understood by people using health services.

120 The development of this preliminary set of National Access Targets has had regard to existing targets and measures in Australia and internationally. It builds upon our earlier work on the development of performance benchmarks in our first report, *Beyond the Blame Game*. It has also built upon existing triage and classification schemes (such as the Australasian College of Emergency Medicine categorization of patients presenting to emergency departments and the Queensland Health urgency classification system for radiotherapy). We would expect that health officials would review and further develop the fine detail of these targets in consultation with relevant health professional groups.

CHAPTER 4

REDESIGNING OUR HEALTH SYSTEM TO RESPOND TO EMERGING CHALLENGES



4. Redesigning our health system to respond to emerging challenges

A long term health reform plan requires us to move beyond the issues of 'here and now' and the current configuration of our health system. It is all too easy to prescribe 'bandaid' solutions that involve patching or 'fixing' existing issues such as lack of access to, or poor quality of, some health services. Many such bandaid solutions also involve making changes in one part of the health system, without recognising that the various elements of the health system are interdependent. It is vital, for example, that proposals for improving access to hospitals build upon recommendations to improve primary health care, and vice versa.

In this chapter, we put forward our recommendations for more fundamental redesign of our health system that will allow us to better respond to emerging challenges. We want to show how these recommendations must permeate our entire approach to how we organise and fund health services in the future.

Taken as a package, our reforms are about transformational change. Our vision of a reformed health system includes:

1. Embedding prevention and early intervention into every aspect of our health system and our lives;
2. Connecting and integrating health and aged care services for people over their lives; and
3. Evolving Medicare – moving beyond the Medicare Benefits Schedule to building the 'next generation' of Medicare.

We will describe each of these major reform elements in this chapter.

4.1 Embedding prevention and early intervention

Among health commentators, it is almost axiomatic to say that we have an excellent 'sickness' system, but not a system focused on keeping us healthy.

Our health system, like those of most other developed countries, provides generally excellent care when people are acutely ill (for example, experiencing a heart attack or suffering major injury in a car accident). But it is largely reactive, not pro-active, reflecting the evolution of health care treating essentially episodic periods of illness and infectious diseases that could not be predicted. As technology has progressed with developments like immunisation and availability of life saving drugs such as antibiotics, the preponderance of more chronic and complex lifestyle illness is more visible.

The availability of preventative interventions, the change in disease patterns, and the ability and support available to introduce and persist with prevention makes this aspect of care a 'no-brainer'. In general, in the past, health professionals waited for 'patients' to present themselves – the health sector does not actively go out seeking to encourage people to keep healthy. Now with a toe in the water, with activities such as preventative health care checks for the 44-49 year olds, for the 75 aged group, and Aboriginal and Torres Strait Islander people, as well as national cancer screening programs, the benefits are apparent. The challenge is to empower the further developments in the sector to succeed and be implemented.

There is not sufficient recognition of our own capacity to take action and improve our own health, supported by our families and communities. We heard about the vital importance of recognising and nurturing self-management to support people to take greater control in managing their health issues:

“Self-management is what most people with long term conditions do – they manage their daily lives and cope with the effects of their condition as best they can, for the most part without any intervention from professionals.”¹²¹

121 Health Care Consumers Association of ACT (2008), Submission 89 to the National Health and Hospitals Reform Commission: First Round Submissions.

“ A cornerstone of reform should be a proactive model for health coaching and care management for citizens which supports self-management and drives a ‘smarter patient’ able to take increased accountability of their own health.¹²²

“ The concept of a partnership highlights the need for health care professionals to understand and respect the role of the carer in achieving maximum health outcomes for their patient.¹²³

These ideas, bubbling out of our submissions, speak to the reality that good health is not something that is simply ‘done’ to us through our interactions with the health system. We must be active participants in our own good health, working in partnership with our health professionals, our carers and families. But this has to occur within the context of our social and economic circumstances and the communities in which we live. The aim has to be to encourage and support everyone to achieve their maximum health potential, regardless of their age or whether they have a chronic illness or a disability.

Our views on prevention and early intervention begin with the valuable contribution of the World Health Organization’s Commission on Social Determinants of Health.¹²⁴ To make it easier for people to lead healthy lives, we support their call for **governments to take action in addressing the social determinants of health**. This includes improving our daily living conditions and the distribution of resources in society – our access to employment, education, housing, a clean environment, and so on. The more equal or fairer a society we have, the better health and social outcomes are for everyone in that society.¹²⁵

Furthermore, governments have a powerful role to play in creating incentives and policies for a health promoting environment to help people make healthier choices. For example, in the tobacco control arena there is clear evidence of the efficacy of combining effective tax measures and social marketing campaigns. This combination represents perhaps the most successful approach to prevention strategies.¹²⁶ In addition, experts have proposed that harmful drinking could be tackled through managing both physical availability and pricing, in combination with social marketing and public education to address the appropriate cultural place of alcohol.¹²⁷

But the real question for us is what actions can we put forward to embed prevention and early intervention into our health system? Our recommendations include a mix of ‘top down’ and ‘bottom up’ approaches.

4.1.1 A new Australian Health Promotion and Prevention Agency

First, we are proposing the establishment of a National Health Promotion and Prevention Agency. This idea – which was also recommended by the National Preventative Health Taskforce – has already been partially picked up in the new National Partnership Agreement on Preventive Health¹²⁸ and included in the Commonwealth Government’s 2009–2010 Budget.¹²⁹ This is a good start, but only a start. We want to be clear that our vision for this agency goes considerably further than what has been agreed to date.

122 Accenture (2008), Submission 3 to the National Health and Hospitals Reform Commission: First Round Submissions.

123 Carers Australia (2008), Submission 55 to the National Health and Hospitals Reform Commission: First Round Submissions.

124 WHO Commission on Social Determinants of Health (2008) Closing the gap in a generation: Final report executive summary.

125 Recent cross-national comparisons have indicated that a constellation of health and social problems (including life expectancy, infant mortality, homicides, teenage births, imprisonment, obesity and mental illness) are worse where there are greater differences or inequalities in income within individual countries. In more equal societies, the improvements in health and social indicators apply to all groups, those on a low income and those on a high income. See: R Wilkinson and K Pickett (2009), *The spirit level: why more equal societies always do better*, (Allen Lane: London).

126 M Wakefield et al (2008), ‘Impact of tobacco control policies and mass media campaigns on monthly adult smoking prevalence’, *American Journal of Public Health*, 98(8): 1443-1450.

127 National Preventative Health Taskforce (2008), *Australia: the healthiest country by 2020* (Commonwealth of Australia: Canberra).

128 All Australian governments signed up to the new agreement on preventive health in December 2008. The agreement is at: http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_preventive_health.pdf

129 Minister for Health and Ageing (12 May 2009), Media release: A new partnership – a new era in health and hospital reform, At: <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2009-hmedia02.htm?OpenDocument&yr=2009&mth=5>

The new National Health Promotion and Prevention Agency should have a broad strategic and tactical role in order to drive a fundamental paradigm shift in how we as Australians, and our health system, think and act about health. This means it must take on much more than 'social marketing' or advertising and education campaigns. It should:

- drive cross portfolio and cross industry sector actions to support a health promoting environment and society;
- have the major responsibility of commissioning, collecting and disseminating evidence on what are 'good buys' in prevention, including primary, secondary and tertiary prevention across health services and other settings. (This is needed to overcome the current 'chicken and egg' problem – we don't invest enough in prevention as we don't have a robust evidence base about the value of prevention, and we don't develop the evidence base as we don't invest in prevention);
- lead the development of new Healthy Australia Goals – where all Australians contribute to setting priorities about the measurement improvements we want to achieve in our health on a regular basis (see Section 5.3.3 for more information on our proposal for Healthy Australia Goals); and
- report to the whole Australian community about whether we are making progress on prevention.

This is a big job. And it needs many hands, not just governments, to get it right. We strongly believe that this new agency should be independent, with a diverse and expert board and the ability to engage with broad cross-sections of the community. Our model is fundamentally about engaging the whole community in prevention – individuals, the health sector, business, public health, researchers, sports, arts, the media, the finance sector, as well as governments.

4.1.2 Shifting the curve of health spending towards prevention

We also need to start investing more in services and population-based interventions that are effective earlier in the course of a person's illness. There is good evidence that some preventive interventions can be an efficient use of our resources.¹³⁰ Like any spending, our investment in prevention should be both clinically effective and cost effective.

Two of our proposals are designed to ensure that we 'shift the curve' of our total health spending towards a greater investment in prevention. First, we have already explained that the new National Health Promotion and Prevention Agency has to take responsibility (with the aid of a dedicated and significant budget) for **building the evidence base as to what works in prevention**. This is essentially what the pharmaceutical industry now does through its research, development and testing of new pharmaceuticals. There is currently no similar 'sponsor' to invest in research on prevention and health promotion, which is why we are recommending that this vital role be undertaken by the new National Health Promotion and Prevention Agency.

But simply collecting the evidence on prevention is not enough. When we think of pharmaceuticals, for example, we have (in highly simplified form) three main steps: the research evidence is developed by the pharmaceutical industry; the Pharmaceutical Benefits Advisory Committee analyses and reviews the cost-effectiveness of 'new' pharmaceuticals against comparators; and a decision is made to fund cost-effective pharmaceuticals through the vehicle of the Pharmaceutical Benefits Scheme (with subsequent negotiation on the price payable by the Commonwealth Government).

Accordingly, we are recommending that we need to put prevention on the 'same footing' through establishing **a common national approach to the evaluation of all health interventions**. This would involve consistent evaluation of medical care, pharmaceuticals, prevention and population health interventions, medical devices and prostheses, allied health services and complementary medicine. To use an example, this might allow comparison of the relative efficacy of a medical intervention (gastric bypass), a pharmaceutical intervention (an anti-obesity drug), an allied health intervention (a structured program of exercises and diet management) and a population health intervention (a community walking program) in reducing obesity.

130 National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, at: www.nhhrc.org.au

A common framework for evaluating health interventions is essential if we are to move away from the existing patchwork of health programs, each with their own funding silos.

4.1.3 Building prevention and early intervention into our health system

Having established the principle that we need to fund effective prevention, we now outline some specific areas where we believe there is good evidence for reorienting our investment around prevention and early intervention.

A healthy start to life

Acting early to keep our children healthy is one of the most powerful investments our society can make. The evidence is overwhelming. If we act early, we can prevent or reduce the magnitude of many disabilities, developmental delays, behavioural problems and physical and mental health conditions.¹³¹ Providing a stimulating balance of quality antenatal and early childhood health services, community and education services is vital for all children. For the most disadvantaged families, a healthy start to life is equivalent to providing a lifeline to help lift children out of generational cycles of poverty and unhealthy environments and give them the best health and life opportunities.

Our recommendations for a healthy start involve ensuring that children get access to the right mix of *universal* and *targeted* services¹³², based on their age and their individual health and social needs. What this would look like is as follows:

- **Before conception:** Universal services need to ensure that people who may become parents are as healthy as possible. Programs to reduce smoking, encourage safe alcohol consumption, tackle the use of harmful drugs and ensure responsible sexual behaviour are examples of important health promotion activities for potential parents. Targeted services would include ways to increase support to teenage girls at risk of pregnancy and young people at risk of sexually transmitted infections;
- **Before birth:** All women would have access to universal primary health care services. These services would be effectively linked with specialist services (including obstetricians and midwives) to ensure that women have choice¹³³ and continuity throughout their pregnancy and antenatal care. Targeted care would be offered for women with special needs or at risk, such as home visits for very young, first-time mothers;
- **Early childhood:** We need to build upon the existing child and family health services (which are different in scope and comprehensiveness across individual states and territories). These services need to be universally available, effectively linked with other primary health services (such as GPs) and other social services (such as early education, welfare and child care) and retain a strong social health model. Our proposal is that all children from birth to eight years of age receive an evidence-based schedule of core contacts to allow for engagement with parents, advice and support, and health monitoring. (For example, this would include a universal home visit within two weeks of giving birth and a six week full baby examination.) The provision of these services should ensure full continuity of care for mothers and their babies across all relevant health service professionals. Services provided by universal child and family health services would include:
 - monitoring of child health, development and wellbeing;
 - early identification of post-natal depression and support for healthy attachment;
 - early identification of family risk and need;
 - response to identified needs;
 - health promotion (for example, support for breast feeding) and disease prevention; and
 - support for parenting.
- **Special needs:** Children with particular health or developmental issues (as identified by the universal child and family health services or the family's primary health care service) would be

131 J Shonkoff and S Meisels (2000), *Handbook of early childhood intervention* (Cambridge University Press: Cambridge).

132 Children with greater or more complex needs would get access to a targeted range of specialist services, in addition to everyone having access to a core package of services for a healthy start to life.

133 Following the completion of the Maternity Services Review, the Commonwealth Government has announced measures to improve choice and access to maternity services.

referred and eligible to get an enhanced package of care (for example, access to specialist services such as paediatricians, allied health, speech pathologists and other services required to manage disabilities or developmental delays). A care coordinator who is linked into a primary health care service would help support families of children with the most complex needs through coordinating and packaging the best range of services for these children and their families.

An important overarching principle is to make best use of all relevant services including child and family health services, child and family health nurses in schools, other primary health care services (such as GPs, midwives and nurse practitioners), and specialist services (including obstetricians, paediatricians, psychologists and speech pathologists). We discuss later (see Section 4.3.2) our recommendation for the Commonwealth Government to assume responsibility for the policy and public funding of primary health care services, including existing child and family health services that are funded and provided through state and local governments. We want to be clear that this proposed integration of state funded primary health care services and general practice should retain the important strengths of each service model. In the context of this discussion on a healthy start to life, this means ensuring that child and family health services continue to provide services under a social health or wellbeing model.

Health promotion in schools

As children enter primary school, child and family health nurses working in schools provide the next important connection on the path to good health. Under our proposal, these ‘school nurses’ would have responsibility for providing the core services in the evidence-based schedule of contacts and health promotion activities for children from five to eight years.

We are recommending that **all primary schools have access to a child and family health nurse** for promoting and monitoring children’s health, development and wellbeing. Universal access to ‘school nurses’ is an important component of our ‘one health system’ approach. Under the proposed integration of all publicly funded primary health care services, we would expect that there are effective protocols and good communication between child and family health nurses in schools and the family’s GP or primary health care service. Both have an important role to play. Primary health care services have responsibility for the continuing management of children’s health, while ‘school nurses’ have a vital role in early identification of disease, health promotion, advice and education to children and their families. Child and family health nurses are also important to support families who might otherwise ‘fall through the cracks’.

Moving on beyond our ‘healthy start’ recommendations, we support more generally the delivery of health promotion and early intervention activities in schools. We would like to see an integrated approach to health promotion, whether it relates to the physical health, mental health, oral health or sexual health of young people.

Children at schools are somewhat of a ‘captive audience’, so health promotion and early intervention programs provided through schools provide the opportunity to reach children who may not routinely use other health services. This is why, for example, we have recommended the **national expansion of the pre-school and school dental programs**. Health promotion and early intervention programs through schools can help instil the habits of a healthy life in our next generation.

Encouraging good mental health in our young people

Young people’s health is often ignored or at least given low priority. Young people often act as though they are invincible. They may avoid seeking medical help, often because health services are not set up in an appropriate ‘youth-friendly’ manner. In reality this group of our emerging generation, our nation’s future, is quite vulnerable, especially when it comes to mental illness. For example:

- most new cases of what become chronic mental illnesses – including psychotic disorders such as schizophrenia – emerge, with often severe impacts, in late adolescence and the early adult years;¹³⁴

134 S Begg, T Vos, B Barker and colleagues (2007), The burden of disease and injury in Australia 2003 (Australian Institute of Health and Welfare: Canberra); and P McGorry, E Killackey and A Yung (2008), ‘Early intervention in psychosis: concepts, evidence and future directions’, *World Psychiatry* 7(3): 1.

- among young people aged 16-24 years, over a quarter reported experiencing at least one mental disorder in the previous 12 months and over 40 per cent of those reported two or more mental disorders;¹³⁵ and
- over one in ten young people aged 16-24 years will have both a mental health disorder and a substance use (alcohol and/or illicit drugs) problem.¹³⁶

The period of adolescence and early adulthood is clearly a high risk transition time in people's lives. Yet it can be challenging to reach young people through conventional health promotion campaigns or to even get them inside the door of mainstream health services. We know that about three in four young people with a mental health problem do not receive professional help.¹³⁷

We cannot afford the loss of life and potential associated with the devastating impact of untreated mental disorders in our young people.

Our recommendations are again grounded in the concept that we should be investing resources in evidence-based, effective early intervention programs to reduce the burden of mental illness. We are recommending the national implementation of two key services as follows:

- **Youth-friendly, community- based services providing information and screening for mental disorders and sexual health:** The first step is about ensuring that we have a youth-friendly approach to screening for mental disorders and sexual health¹³⁸ that is accessible to all young Australians.¹³⁹ Services need to be comprehensive and provided through a range of modalities including face-to-face, telephone and internet based approaches. Some young people will be able to receive sufficient information and support through these services that they require no further care. But these services would also need to refer young people with particular problems (such as early psychosis, substance abuse, eating disorders, binge-drinking, personality disorders, risky sexual behaviours) to other services including primary health care services and/or relevant specialist services (specialist mental health, alcohol and drug services, addiction clinics etc). The need for comprehensive medical care is vital as this cohort has disproportionately worse physical health outcomes than their peers at each stage of life; and
- **Specialist clinical services for prevention and intervention of early psychosis:** The next step is filling the service gap in managing young people who are diagnosed with early psychosis. We are recommending the national rollout of the Early Psychosis Prevention and Intervention Centre model. This involves case managers and clinical experts working closely with young people to help them adjust to their diagnosis, receive early treatment and continue to live at home. The evidence is that this approach results in fewer unplanned hospital visits and helps improve functioning and social outcomes for affected young people.¹⁴⁰

Health promotion and good health at all ages and abilities

While we have focused in the above discussion on our children and young people, we are strongly of the view that prevention, health promotion and early intervention should be incorporated for people of all ages and abilities, and across as many 'settings' as possible. We use the term 'settings' to refer to the different locations in which health promotion can take place – this includes schools, workplaces, community groups and sporting clubs, as well as in the course of our use of health services (sometimes called 'opportunistic prevention'). Hence, we have recommended, for example, that **governments review any regulatory barriers to support the expanded provision of health promotion programs** in different settings including by employers and private health insurers.

135 Australian Bureau of Statistics (2008), National survey of mental health and wellbeing: Summary of results (Australian Bureau of Statistics: Canberra).

136 Australian Bureau of Statistics (2008), National survey of mental health and wellbeing: Summary of results (Australian Bureau of Statistics: Canberra).

137 G Andrews, S Henderson and W Hall (2001), 'Prevalence, comorbidity, disability and service utilization: overview of the Australian national mental health survey', *British Journal of Psychiatry* (178): 145-153.

138 We have included sexual health as part of these services as there is evidence of under-utilisation of these services by adolescents.

139 There are some existing models such as headspace, but these services are yet to be rolled out on a national basis.

140 P McGorry, E Killackey and A Yung (2007), 'Early intervention in psychotic disorders: detection and treatment of the first episode and the critical early stages', *Medical Journal of Australia*, 198 (7): S8.

We want to stress the value of prevention, health promotion and early intervention regardless of people's age, health status or disability. It is important that everyone – including older people living in residential aged care or in the community, people with an intellectual disability, people living with a degenerative condition (such as multiple sclerosis) and people with other complex and chronic conditions – is given the opportunity to achieve their maximum health potential. We agree with the views articulated in one of our submissions:

“ Ensuring a healthy start to the third age will provide the most immediate benefits to individuals facing increasing age-related risks of many conditions, and also to the health care budget... To ensure that as many people as possible enter retirement in the best possible health, there is a need to develop more age-related initiatives within the broad preventative and health promotion strategies, and to supplement these initiatives with age-specific initiatives.¹⁴¹

We cannot describe every evidence-based early intervention or promotion program in this report. Moving towards greater provision of these services for people of all ages and abilities has to be a fundamental building block of reforming our health system.

4.2 Connecting and integrating health and aged care services for people over their lives

Currently our health system works reasonably well if people have acute or emergency problems that can be quickly resolved through one-off medical interventions. However, the needs of people living with chronic diseases, people with multiple complex health and social problems, and older, increasingly frail people are less well met. When we consider the balance and organisation of our health services, it is evident that our health system has not been designed around the needs of such people with more complex and long-term health problems.

“ Imagine if, when your car develops minor mechanical trouble, you had to go to one place for a diagnosis, another for parts, another for some repairs, another for some other repairs, with different bills from each provider – and with the complication of having to drive around in a defective vehicle to obtain all these parts. This is what would happen if your car was being treated in Australia's antiquated health program structure. Program divisions are based on providers' demarcations, rather than consumers' needs. There is no consistency to the way the payments are structured and there is a confusing array of programs. This is detrimental for consumers and a significant obstacle to a person and family-centred health system.¹⁴²

The people in most need are often the least well equipped to navigate their way around our incredibly complex health system.

141 Anna Howe (2008), Submission 222 to the National Health and Hospitals Reform Commission: First Round Submissions.

142 CHOICE (2008), Submission 63 to the National Health and Hospitals Reform Commission: First Round Submissions.

For many people, health care is synonymous with hospitals. We judge our health system on how well public hospitals are performing; stories in the media concentrate on problems with waiting lists or patients being harmed in hospitals; and it is commonplace for major infrastructure investments in health to be spent mainly on acute hospitals.¹⁴³ While it is absolutely essential that we continue to ensure the delivery of high quality and accessible acute hospital services, this should not be at the expense of other parts of the health system. The challenges of an ageing population and the growth of chronic diseases create an urgent imperative to provide access to a broader range of health services in the community. As we heard:

“ The current situation of using hospitals to assess and manage almost all acute episodes of care for older people is unsustainable given the demographic changes over the next 20 to 40 years...This requires a change of mind-set to see the community as the natural setting for health care with the hospital as the expensive alternative if the illness is severe, requires surgery or high technology.¹⁴⁴

The underlying premise of our recommendations in this section of our report is that we need to redesign health services around people, making sure that people can access the right care in the right setting. This must include a ‘full service menu’ of health and aged care services necessary to meet the needs of an ageing population and the rise of chronic disease. Redesign also involves ensuring that this complex array of services is well coordinated and integrated through more effective use of tools including standard assessment tools (to augment good clinical method), agreed communication systems with some built in protocols, shared understanding of care pathways and engaging the whole health care team, reforms to funding and embedding data systems for clinical and management purposes that promote better continuity of care and multidisciplinary collaboration across health care professionals.

4.2.1 Primary health care as the cornerstone of our future health system

Our vision for a future health system involves revitalising and strengthening primary health care services. While Galileo was excommunicated for suggesting that the earth revolved around the sun, we don’t think it is too heretical to suggest that primary health care services should be the axis or pivot around which we seek to develop a person-centred health system. Indeed, we heard broad support throughout our consultations for expanding the role of primary health care services to take on this role.

Our recommendations to achieve this are in several parts.

Bringing together and integrating multidisciplinary primary health care services

First, we want to make sure that we make best use of all primary health care services. We are recommending that **the Commonwealth Government take responsibility for the policy and public funding of primary health care services** that are currently funded by state, territory and local governments. This includes, for example, community health services, family and child health services, community nursing, allied health, and alcohol and drug treatment services. We believe that there needs to be significant investment in primary health care infrastructure. This must involve developing an integrated plan for the development and networking of all publicly funded primary health care services. To do this, we need to bring together general practice (funded by the Commonwealth Government) and primary health care services (currently funded by state and territory governments).

¹⁴³ While hospitals may attract most infrastructure investment, this is sometimes skewed to high cost machines that go ‘ping’. Key buildings and maintenance are often overlooked, while the ‘rolling stock’ in our hospitals erodes and fades in utility. Key infrastructure such as information technology, that is not immediately visible, is left in ‘legacy mode’ that renders it obsolete and denies the health system and its consumers and proponents the productivity, efficiency, safety and quality drivers that these can deliver.

¹⁴⁴ John Ward (2008), Submission 368 to the National Health and Hospitals Reform Commission: First Round Submissions.

Investing and building comprehensive primary health care

General practitioners are already the most visited health professional, with about 85 per cent of the population seeing a GP at least once a year.¹⁴⁵ We want to build upon this and improve access to a more comprehensive and multidisciplinary range of primary health care and specialist services in the community. Our proposal for the establishment of **Comprehensive Primary Health Care Centres and Services** is about providing a 'one-stop shop' approach so that patients can get access to an expanded range of services (for example, pathology, imaging, community nursing, allied health), with better coordinated referrals and networks of services (including good linkages with specialists, mental health services, family and child health services, community care and aged care services) at more convenient times through extended opening hours.

We received considerable feedback and recognise that comprehensive primary health care is likely to include both 'physical' Centres and 'virtual' Services. Accordingly, we are proposing that the Commonwealth Government **provide a mix of capital and establishment grants** to promote the development of Comprehensive Primary Health Care Centres and Services. Existing primary health care service providers could combine and evolve into these larger groups, while the Commonwealth Government might also target the development of new Comprehensive Primary Health Care Centres and Services in areas where there is now limited access to these services.

Encouraging better continuity and coordinated care

People with more complex health problems need a 'health care home' that can help coordinate, guide and navigate access to the right range of multidisciplinary health service providers. As we have already said, the people most in need are likely to have the greatest difficulty in getting the right care. Sometimes, such patients end up literally ricocheting between multiple specialists and hospitals, not getting access to community support services, and having endless diagnostic tests as each health professional works on a particular 'body part', rather than treating the whole person.

This is why we are recommending that people with more complex needs (including some people with chronic diseases, long-term mental health problems, physical and intellectual disabilities, families with young children, and Aboriginal and Torres Strait Islander people) be encouraged¹⁴⁶ to 'enrol' or 'register' with **a single primary health care service of their choice that would become their 'health care home'**. We will discuss in Section 5.4.1 some of the changed funding arrangements under the Medicare Benefits Schedule that would support this reform. But from the perspective of patients, what this would mean is that their primary health care service would take more responsibility in coordinating their care across all their health service needs and patients would be able to get access to additional services that are not currently included under the Medicare Benefits Schedule.

Supporting better service coordination and population health planning

We believe that primary health care services need to be supported to take on broader roles related to service coordination and population health planning. This goes beyond the provision of primary health care treatment to individual patients. Currently, Divisions of General Practice undertake this broader role. In line with our recommendations to integrate state-funded primary health care and general practice, we believe that **Primary Health Care Organisations should be established**, evolving from or replacing the existing Divisions of General Practice.

Promoting better use of specialists in the community

Well-coordinated primary health care is only part of the solution for people with chronic diseases (such as diabetes, heart failure or kidney failure) and other complex health needs (such as people with cancer or children with severe developmental delays). Specialists are central to the shared management of care for many such patients and have a critical role in assessment, complex care planning and consultancy support and advice to patients and their primary health care teams.

¹⁴⁵ Australian Institute of Health and Welfare (2008), *Australia's health 2008*, (Australian Institute of Health and Welfare: Canberra).

¹⁴⁶ Our proposal is for voluntary enrolment of such patients. We anticipate that as people see the benefits of having a 'health care home' there would be wide take-up of enrolment among this population with complex health needs. Many people are already having their care managed by a single primary health care service.

Many specialists (such as paediatricians at the beginning of life, geriatricians at the end of life, and a whole host in between) already provide most of their care to patients in the community, not patients admitted to a hospital bed. The 'out' in traditional outpatient services is increasingly shifting outside the walls of hospitals. We want to see the best models of care for patients that bring together specialists and primary health care professionals to improve health for the most complex patients across all settings, hospitals and the community. Several of our proposals are intended to build better networking and integration of primary health care and specialist services.

We believe that giving the Commonwealth Government new responsibility for the funding of outpatient services and state-based community health services, together with its existing responsibility for funding general practice and private specialist services, will remove some of the artificial funding barriers to how these services currently operate. We also anticipate that the strengthened platform of primary health care services will act as a more effective hub, attracting and building stronger relationships with specialist teams in the community.

The take-home message of our primary health care proposals is that strengthened primary health care services in the community should become the 'first contact' for providing care for most health care needs for most people. This builds upon the vital role of general practice, and allows the creation of a comprehensive platform of primary health care bringing together health promotion, early detection and intervention and the management of people with acute and ongoing conditions.

4.2.2 Creating 'hospitals of the future' and expanding specialty services in the community

Another key plank in redesigning our future health system involves rethinking how we plan and use our most highly specialised services.

The role of hospitals, and how specialty services are provided, has changed dramatically over the past 100 years. Once upon a time, hospitals provided little more than solace and isolation to people afflicted with infectious diseases such as leprosy, polio and diphtheria. But as technology and medical advances transformed our capacity to save lives, hospitals evolved into places that provided highly specialised services with most people beginning and ending their lives in hospitals.

The way in which hospitals are being used continues to evolve. The average length of stay is now measured in days, not weeks or months. And over the last decade or so, many highly specialised services have moved back outside the hospital walls and into the community. Quite complex treatments such as dialysis and chemotherapy are now being provided to some patients in smaller community facilities (for example, 'satellite' dialysis centres) or in their own homes. Hospital in the home programs, the growth of community nursing, and the development of specialist clinical teams in the community have provided people with more choices about how to access highly specialised care.

Our reform proposals are based on two related ideas:

- **Getting the best value from our hospitals** – we want to ensure that we use these valuable assets and the skills of our hospital staff wisely; and
- **Providing more options for people to receive care in the community** – we want to expand the provision of a range of specialist services in the community that are the 'bridge' between primary health care services and hospitals. In particular, our recommendations identify the need to invest in sub-acute services, mental health services and palliative care services.

We turn now to some of the specific proposals that will give effect to these concepts.

Reshaping hospitals

We have already identified several reforms to achieve better access to acute hospitals. Our proposals around the introduction of National Access Targets, together with new funding arrangements to improve access to emergency care through supporting 'emergency access' bed capacity in hospitals with major emergency departments, are two significant components in what must be a multi-layered strategy. (We also highlighted in Table 2.1 that many of the changes required to improve access to hospital care involve better use of health services outside hospitals).

Another key reform component involves **separating the provision of elective and emergency services in public hospitals**. What happens frequently now is that these patients compete (unknowingly) to get access to the same beds, operating theatres and hospital staff. Patients with planned surgery may be cancelled as emergency patients take priority. We are recommending that the planning and funding of public hospitals allow for the establishment of separate planned surgery facilities, either within the one hospital or as stand-alone facilities. According to the Royal Australasian College of Surgeons:

“ Elective surgical services should be quarantined from acute services to provide more efficient and predictable patient outcomes. Access to surgeons in the hospital with availability to theatres in a very prompt manner is essential for more reliable emergency surgery.¹⁴⁷

Of course, such delineation of roles needs to recognise the reality that patients do not come with neat labels on their foreheads and a routine patient can rapidly become an emergency patient, especially if there are delays in accessing treatment. Clearer separation of elective and emergency services also needs to be done in such a way that maintains the vital teaching role of hospitals including exposing medical, nursing and other health professional staff to a broad range of patients and learning environments, as well as research.

We are also recommending that the **provision of public hospital outpatient services be reviewed** to ensure that they are more closely designed around the needs of patients, including providing more of these services in community settings outside hospitals. Outpatient services have been described as the 'poor cousins' of the Australian health system – 'a remnant of the pre-Medicare system which provided free specialist care for "the poor"'.¹⁴⁸ The traditional organisation of outpatient departments – large waiting rooms, block appointment sessions rather than scheduled consultations, and lack of continuity of staff involved in monitoring a patient's care – did not put patients first. While there have been some improvements, more needs to be done to create a more responsive, patient-focused model of delivering outpatient specialist care. This includes better integration of these specialist services with comprehensive primary health care and locating more specialist services in the community.

Investing in sub-acute services

To refresh people's memories about our language, we described sub-acute services in our Interim Report as including rehabilitation, geriatric evaluation and management services, transition care and other 'step-up' or 'step-down' programs.

We know that many parts of Australia have limited or poorly developed sub-acute services. This means, for example, that people may not get adequate rehabilitation following a stroke or a heart attack or a hip replacement to allow them to return to as active a life as possible. (Historically, our health system has focused on tackling the immediate risk of people dying from acute conditions, but has invested less in the ongoing, and sometimes slow, process of helping people recover and reduce the impact of complications following an acute illness). But sub-acute services may also help people avoid unnecessary visits to hospitals or premature admission to a residential aged care service.

¹⁴⁷ Royal Australasian College of Surgeons (2008), Submission 406 to the National Health and Hospitals Reform Commission: First Round Submissions.

¹⁴⁸ T Jackson, J Watts, D Muirhead and P Sevil (1997), Non-admitted patient services: a literature review and analysis, Report prepared for the Victorian Department of Human Services.

Some examples include services to reduce the risk of elderly people falling or programs that allow people with chronic disease to better manage their care at home and avoid emergency visits to hospitals. We heard considerable support for providing better access to sub-acute services:

“ Timely return home after acute hospital stays must be supported by adequately resourced programs such as postacute geriatric rehabilitation, transition care, home delivered personal health care and access to in-home and residential respite, as well as access to permanent residential care...Community support must be an ever evolving program to ensure maintenance of autonomy, fostering independence and limiting dependency.¹⁴⁹

Accordingly, we are recommending **a substantial investment in, and expansion of, sub-acute services** including a major capital boost to build the missing facilities required to provide sub-acute care. We recognise that much sub-acute care can be provided on an ambulatory (or non-inpatient basis) and can be provided outside acute hospitals. We need extra capital investment for these ambulatory services, but we also need significant investment in more sub-acute ‘beds’ in inpatient facilities. And, of course, we need to ensure that we have **an appropriately trained workforce available to deliver this expansion in sub-acute services**.

Our recommendations on investing in sub-acute services go further than what has already been agreed to by the Council of Australian Governments in December 2008.¹⁵⁰ State and Territory governments have agreed to expand sub-acute services by five per cent each year over the next four years. We expect that much of this will be consumed by the usual extra demand associated with an ageing and growing population, and this level of growth does not adequately recognise the need to first achieve a minimum acceptable level of sub-acute services across the country. In addition to extra recurrent funding, there will need to be investment in capital infrastructure for sub-acute services. This needs to be complemented by **expanded access to independent living aids and equipment** that allows people to better manage their health conditions while living at home.

Connecting care and support for people with mental illness

We have already discussed two aspects of our recommendations for improving care for people living with mental illness – the need to provide better access to crisis mental health services (see Section 3.2.3) and the need to invest in early intervention programs to reduce the burden of mental illness among young people (see Section 4.1.3).

A major focus of our deliberations on supporting people living with mental illness has been the need to provide treatment and support for the whole person that is connected across the whole spectrum of health and social support services (including employment support and assisted housing). Some might argue that everyone using health services needs ‘connected care’ and should receive care that is holistic. We do not disagree. But these needs are intensified for people living with mental illness.

We know that there is better capacity to recover from severe mental illness when people are able to work productively, to access suitable education and training, and to live in a safe environment. Without these supports, people with severe mental illness can experience a downwards spiral that impairs their ability to live a normal life. Accordingly, we have recommended that people living with severe mental illness get **access to stable housing that is linked to support services**. This must be complemented by **additional investment in social support services**, particularly vocational rehabilitation and post-placement employment support.

149 National Aged Care Alliance (2008), Submission 453 to the National Health and Hospitals Reform Commission: First Round Submissions.

150 Council of Australian Governments (2008), National Partnership Agreement on Hospital and Health Workforce Reform, at: http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_hospital_and_health_workforce_reform.pdf

We have already discussed the value of ‘sub-acute’ services for people experiencing a physical illness. The same concept applies to people living with a mental illness. We are recommending that there needs to be a **major expansion of multidisciplinary community-based sub-acute services** that are effectively linked in with hospital-based mental health services. These sub-acute services can help manage the care of people living in the community before they become acutely unwell (step-up care) and provide an alternative to support recovery and better functioning after an acute hospital admission (step-down care). This ‘prevention and recovery’ model is a vital element in effectively supporting people with a mental illness living in the community. Investing in community-based outreach, sub-acute services and earlier intervention will help free up existing acute mental health services for more optimum use of these services. While some additional investment in acute mental health services may be warranted, the balance of future investment should seek to reorient mental health services with a greater focus on prevention, early intervention and sub-acute services in the community.

Improving access to palliative care services

A common theme across many of our recommendations has been about improving access to a range of specialty services, some of which are currently available in only limited settings. The existing organisation of some specialist services reduces the ability of patients to access care where and when they most need it.

One example is specialist palliative care services, which are usually based in public hospitals. In many states, there are limited options available for people to receive care and support from specialist palliative care services in their homes, or in private hospitals, or if they are living in a residential aged care service. We heard that:

“ *The current experience of end of life care in Australia is disparate and inconsistent and we cannot, in good faith, promise patients at the end of their life access to care that is customised to preferences and reliably delivers good symptom control. Our health system can do better.*¹⁵¹

Our recommendations are intended to tackle this problem in two main ways.

First, we have argued that in line with our recommendations for strengthening primary health care, we need to be **building the capacity and competence of primary health care services to provide generalist palliative care support** for their dying patients. Most people who are dying will not need to be directly cared for by specialist palliative care practitioners. Instead, specialist palliative care services can provide stronger outreach and support to Comprehensive Primary Health Care Centres and Services to allow them to provide a palliative approach in the care of dying patients.

Second, we have recommended that there should be **additional investment in specialist palliative care services** to allow better access for people at home in the community (including people living in residential aged care services). We believe that where it is clinically and cost effective, there needs to be an option that allows for ‘care to be brought to the patient’, rather than the only option being that ‘the patient must be brought to the care’. This is another example of the general concept we support of creating ‘hospitals without walls’.

4.2.3 Increasing choice in aged care

To address one of our terms of reference, ‘to better integrate acute services and aged care services, and improve the transition between hospital and aged care’, we make recommendations regarding the provision and financing of aged care services. The health and aged care ‘systems’ are like two giant interconnecting cogs – if they fail to ‘mesh’ together, the end result will be inappropriate care and poor outcomes for people.

Our recommendations on aged care services were shaped by several factors:

151 Palliative Care Australia (2008), Submission 142 to the National Health and Hospitals Reform Commission, First Round Submissions.

- we are facing huge growth in demand for aged care services. Using the current targets for provision of aged care, between now and 2030, the number of aged care places (covering both residential and community-based aged care services) will need to at least double (from 223,000 places to about 464,000 places) as the number of older people in our community increases;¹⁵²
- however, factors other than an ageing population are creating new pressures and challenges to how we provide aged care services into the future. The baby boomer generation, now advancing in years, has much higher expectations for choice, responsiveness and flexibility in how they access aged care services than previous generations. Smaller families and increasing workforce participation will mean reduced availability of family carer support;
- existing aged care funding arrangements are complex and highly regulated, driven by the Commonwealth Government's need to manage the fiscal risks of aged care services. The Productivity Commission has described the current situation as follows:

“ There are concerns about the degree to which the provision of aged care services is shaped by centralised planning and administrative processes, extensive government regulation and high levels of public subsidy. There are also concerns that the system is overly fragmented and difficult to access and navigate, reflecting the existence of multiple programs... The ability of older Australians to exercise choice is limited by regulatory and financing arrangements that effectively ration the quantity, and limit the mix, of available services.¹⁵³

- finally, the aged care sector continues to express concern about the industry's financial viability, flowing from the current regulatory and financing arrangements.

Hence, our recommendations seek to balance three goals: ensuring greater choice and responsiveness for consumers; getting the most effective use of public monies while protecting those older people who are most in need; and creating an environment that fosters a robust and sustainable aged care sector.

We believe that our recommendations about sub-acute care will have a significant impact on aged care. Enhancing sub-acute services will achieve the dual objective of reducing the number of people accommodated inappropriately in acute hospitals and the flow of people into aged care by helping people to achieve greater independence after an acute hospital visit (for example, recovering from a stroke).

Our proposals for major reforms to aged care, canvassed through our Interim Report, generated considerable debate. Much of the feedback was positive, while recognising the vital importance of a carefully managed approach to implementation of large-scale reform to the financing and regulatory framework for aged care. We heard:

“ The National Health and Hospitals Reform Commission recommendations on aged care present clear and purposeful reforms that are consistent with – and advance – progressive recommendations from consumer, provider, and expert groups over the last decade.¹⁵⁴

152 Calculated by applying the current target ratio of 113 aged care places for every 1,000 people aged 70 or more to the projected population aged 70 or more, using Series C from: Australian Bureau of Statistics (2008), Population projections Australia (Commonwealth of Australia: Canberra).

153 Productivity Commission (2008), Trends in aged care services: some implications, Research paper (Commonwealth of Australia: 2008).

154 H Kendig (2009), Submission 205 to the National Health and Hospitals Reform Commission: Second Round Submissions.

“ We are supportive of the broad directions for reform of aged care outlined in the Interim Report... We have also noted the need for careful staging of any changes to ensure that there is no disruption in the provision of high quality client-centred services to consumers; that the flexibility and capacity of services to respond to changing patterns of demand is enhanced; and that organisations are able to respond to changing business environments and maintain continuity of service.¹⁵⁵

We now explain our recommendations, telling the story first from the perspective of older people needing access to aged care services, and then from the perspective of aged care providers and the Commonwealth Government.

Impact on older people

Assessments are the gateway through which older people must pass to gain government support for access to aged care services. We are recommending that **existing assessment processes be streamlined and integrated**. This means that regardless of whether people are ultimately assessed as needing Home and Community Care services, community-based aged care services or residential aged care services, there is a single, common integrated assessment approach (with simple assessments for low levels of support at home, through to more rigorous assessment to determine eligibility for higher levels of community and residential care).

Following assessment, we want to ensure **greater choice and responsiveness** in how older people use aged care services. This has several elements:

- **More aged care places to choose from:** We recommend that the current restrictions on the number of aged care places an approved provider can offer be lifted. This means good aged care providers will be able to take as many people as wish to use their services, and older people will no longer have to accept the only place they can find. Aged care services will compete with each other to attract older people. Older people who are unhappy with their care will find it easier to shift to a different service;
- **Information to support effective decision-making:** We are recommending that aged care providers make standardised information available on service quality and quality of life issues, so that older people and their families can make meaningful comparisons in choosing an aged care service;
- **Government subsidies aligned to assessed needs:** Currently government subsidies for people receiving aged care services in the community are organised into what are essentially three ‘steps’ – Home and Community Care packages, Community Aged Care packages and Extended Aged Care at Home packages. But older people may have needs that fall above or below these three categories of government subsidies. There is also a disconnect between how subsidies are determined for people receiving community aged care versus residential aged care (where a new tool called the Aged Care Funding Instrument is used to determine the level of government subsidy). We are recommending that there be a more flexible range of care subsidies for people needing community care packages, determined on a basis which is consistent with subsidies for residential aged care;
- **Consistent use of consumer payments across aged care:** The charging arrangements across the spectrum of aged care services can create perverse incentives so that people do not necessarily get the right care. We have recommended that payments made by consumers should be similar for similar services, regardless of whether care is provided in the community or in a residential aged care facility;

155 Aged and Community Services Australia, Aged Care Association Australia, Alzheimer’s Australia, Anglicare Australia, Carers Australia, Catholic Health Australia and Uniting Care Australia (2009), Joint submission 273 to the National Health and Hospitals Reform Commission: Second Round Submissions.

- **Increased choice in how aged care services are accessed:** We recommend that older people should have greater scope to choose between whether they get care in the community or in an aged care facility. People who have the most complex needs and frailty (including people with advanced dementia), will often be best served by residential aged care, with access to around the clock care and support, to ensure they receive adequate care. However, we recognise the value of moving towards 'consumer-directed care', where older people can have more say in tailoring the package of services that they use to best meet their assessed needs. While such an approach will need to be developed and introduced over time, our recommendations support giving people receiving care in the community greater choice in how the resources are allocated, and to whom, for their care and support; and
- **Better access to health information, advice and technology support at home:** For older people receiving care in the community, we have recommended that they be supported through improved access to e-health, online and telephonic health advice, together with home and personal security technology. We also want to improve the safety, efficiency and effectiveness of care for all older people by giving them the option of having a person-controlled electronic health record (see Section 5.3.1 for further information).

Impact on aged care providers and the Commonwealth Government

Behind the scenes, there are a series of reforms that are required to give effect to this greater consumer choice and responsiveness in how older people access and use aged care services. Our other recommendations also seek to balance the objectives of fiscal sustainability for the Commonwealth Government and ongoing viability of the aged care sector as follows:

- **Linking government funding to people:** The Commonwealth Government now provides subsidies for 'places', either in residential aged care or in community care. This is driven by a 'top-down' approach to planning aged care services, through a complex set of planning ratios which determine the level and mix of aged care services. The result is places are scarce and high levels of occupancy are the norm. This does not give older people much opportunity to 'vote with their feet' in choosing between aged care services, as the supply of services is tightly regulated. Our recommendation is that Commonwealth Government funding subsidies for aged care should be more directly linked to people's needs, rather than places. This would involve removing the current planning ratios, but instead capping the number of aged care subsidies at the point of assessment;
- **Ensuring government support keeps pace with the number of people needing care:** The current planning ratio for aged care is based on the number of people aged 70 or over. However, people taking up community aged care packages or entering residential aged care do so, on average, when they are 83. The major users of aged care are people in their mid eighties, and the number of people aged 85 or over will grow faster in the next five years and especially in the longer term, than the number of people aged 70 or over. This means that despite the levels of growth that will result from the current planning ratio, provision will decline relative to the numbers of people needing aged care. This will mean more people unable to receive the care they need, and more older people having to seek care in hospital for want of access to aged care. To remedy this, we recommend that the numbers of people eligible for government support for aged care be linked to the number of people aged 85 or over.¹⁵⁶ We should clarify that using the numbers of people in this older age group to determine the number of people who will be supported to receive aged care does not mean that people younger than 85 will have less access to aged care than currently. Just as some people younger than 70 are supported to receive aged care currently, many people younger than 85 would be supported in the future. We believe that these changes would encourage greater provider competition and a stronger focus on quality and service;

¹⁵⁶ This would involve calculating an equivalent ratio. If the aged care places available in mid-2007 were expressed as a ratio to the population of people aged 85 or over, it would be equivalent to 620 places per 1,000 people. This compares with the existing planning ratio of 113 places per 1,000 people aged 70 or over.

- **Funding greater choice:** We recognise that aged care providers will need to be able to raise revenues to invest in expanding the number of aged care places in order to offer more choice for older people. We have recommended that consideration be given to allowing accommodation bonds, or alternative approaches to payment for accommodation, for people entering high care residential care places, if the removal of regulated limits on the number of aged care places has resulted in sufficient increased competition in supply and price across the aged care sector. In addition, aged care providers should be given the opportunity to convert existing low care residential places to community care in a phased way to free up the choice of care setting for older people;
- **Adequacy of funding subsidies:** The increasing frailty of older people has implications for the level of care and support that must be provided. We have recommended that the level of care subsidies be periodically reviewed to ensure that they are adequate to meeting the care needs of very frail people in residential settings. Ensuring adequate care subsidies is also essential if aged care facilities are to provide sufficient appropriately trained professionals, including nurses, to meet the complex health needs of residents;
- **Dedicated funding for medical care:** We are aware that there is a significant problem in some aged care facilities with patients not being able to readily access medical care. We have recommended that funding be provided directly to aged care providers to organise the provision of medical services for their residents, including through 'sessional' (part-time) and on-call arrangements. This does not remove the right of aged care residents to choose their own doctor and to enrol voluntarily with a primary health care service. Instead, this reform is intended to fill an existing gap in the provision of medical services to aged care residents.
- **Consolidating aged care under the Commonwealth Government:** We have recommended that the Commonwealth Government assume full responsibility for all aged care services. This would include transferring responsibility for the Home and Community Care program aged care services and Aged Care Assessment Teams from states and territories to the Commonwealth Government. This will enable the development and adoption of simplified and integrated assessment across all forms of aged care, and will also enable more integrated provision of aged care across the spectrum from low levels of support in the community through higher levels of community care, to high level residential care.

We believe that this package of reforms is necessary to reposition our aged care services to meet the coming challenges ahead, while improving consumer choice and responsiveness and promoting fiscal sustainability for the Commonwealth Government.

4.3 Evolving to 'next generation' Medicare

Our discussion up until now has focused very much on how an integrated health and aged care system would work from the perspective of patients. That is rightly the story we should tell first. But we also need to identify and explain the 'back of house' changes. That is the purpose of this section, where we pull together and explain our recommendations for building the 'next generation' of Medicare.

4.3.1 Overview

Most Australians still think of Medicare as about paying for medical services. There is no doubt that medical services are, and must remain, the essential foundation of Medicare. We have a world-class approach to medical education and an enviably high standard of care provided by medical practitioners, including our general practitioners and specialists, working in the community, in hospitals and in other settings. We need to be clear that our reforms to Medicare in no way seek to compromise or reduce the vital and indispensable role of medical practitioners in our health system.

However, we believe that there are major opportunities to build upon the strengths of our current Medicare framework and signal the direction for how Medicare could evolve in the future. Table 4.1 provides a snapshot of how Medicare operates now and how Medicare might operate in the future as a result of our recommendations.

Table 4.1: An evolving Medicare

Medicare now	An enhanced Medicare in the future
Medical services (in the main)	Supplements medical services with a broad package of health services (allied health, nursing and other health professionals) to support complex and continuing care
Based on consultation between one patient and one medical practitioner	In addition to personal individual consultations, encourages and supports team-based and multidisciplinary care
Pays benefits to patients for services delivered by private practitioners (mainly GPs and medical specialists)	Adds to current benefits as it pays for a mix of private and publicly delivered services (expanded to cover state-funded primary health care services, public hospital outpatient specialist services and selected allied health and other health professional services)
Fee-for-service payments for each visit	Broadens the mix of payment arrangements including fee-for-service, payments for course of care or period of time, grants, outcome payments, salary. Payment depends on type and value of service and provider
Mainly focused on consultation, diagnosis and treatment, often related to specific problems or diseases	Adds greater scope to support stronger focus on prevention, health promotion, early intervention and wellbeing, including supporting people in self-management
Benefits based on who delivers the service (and whether it is safe and cost-effective)	Supports a broader range of specified services by health professionals providing care within their defined scope of practice (and whether it is safe and cost-effective) and for innovative, collaborative care models within services
Choice of GP	Choice of GP continues (now encouraged to be part of an expanded primary health care service)
People may visit many GPs, use a mix of referred and other non-referred services, including diagnostic tests, but often struggle to find the right mix of health and community support services	People with more complex health problems will have the choice of having a single 'health care home'. By registering with a primary health care service, these people will be eligible to access additional services. The primary health care service will coordinate access to all the health care needs for individuals
People may face different co-payments for medical services and for other services outside Medicare	Development of more integrated safety net arrangements that protect people from unaffordable costs
Pays benefits for face to face services involving a patient and a medical practitioner	Also pays for different types of services – email, telephone, telehealth (e.g. video conference) – that do not involve physical presence of patient. Payment for these services may be part of episodic payment or grant payments
Pays for medical services delivered by doctors based on where they choose to practise	Also supports better distribution of services by funding primary health care services in 'under-served' areas – includes top-up payments for some remote and rural communities and grants to encourage establishment of Comprehensive Primary Health Care Centres or Services in under-served areas

Our rationale for proposing this evolution of Medicare is based on a range of important objectives. We want:

- to ensure that all Australians, regardless of where they live, can **access** primary and specialist health services (including medical and non-medical services);
- to create an **integrated and comprehensive platform of primary health care services** that brings together private medical services funded under the MBS with state-funded community health services;
- to promote **continuity and better coordinated care** across all health care professionals, particularly for people with the most complex health needs;
- to be able to respond effectively to the **tsunami of chronic disease** that poses new challenges for how we organise and provide health services in a way that best meets peoples' needs;
- to encourage a greater emphasis on **prevention, early intervention and self-management**;
- to support **evolving clinical practice and effective value-based use of all health resources** (including medical, nursing, allied health and other clinical staff);
- to support **new and effective ways** of providing health services more responsively to people that recognise new technologies, clinical innovation and changes in the way we live our lives; and
- to improve the **quality of health services** including supporting health professionals in continuing education and research, the translation of research into clinical practice, and the implementation of measurable improvements in quality of care.

4.3.2 Bringing together state-funded health services and MBS services

We believe that there are major opportunities for Medicare to evolve, flowing from our recommendations that the Commonwealth Government:

- assumes policy and funding responsibility for existing state-funded primary health care services (see Section 4.2.1); and
- meets 100 per cent of the efficient cost of public hospital outpatient services using an agreed casemix classification and an agreed, capped activity budget (see Section 6.4.3).

In both cases, these changes in roles and responsibilities between governments will require matching adjustments to grants from the Commonwealth Government to states and territories. That is, the increased responsibility of the Commonwealth Government is funded through commensurate reductions in grants to the states and territories.

Among other things, these changes provide the opportunity for the Commonwealth Government:

- to 'add' in the services of selected other (non-medical) health professionals under Medicare through different payment arrangements rather than using only fee-for-service (which has largely been the model used to date);
- to recognise and support the valuable contribution of health promotion, early intervention and social health models in primary health care;
- to bring together the broad array of services (medical, allied health, nursing and other services) that would form the backbone of the proposed Comprehensive Primary Health Care Centres and Services;
- to better understand the models of care for the provision of multidisciplinary specialist services currently delivered through state public hospital outpatient departments as a basis for designing payment arrangements that foster multidisciplinary care under the MBS in the future;
- to aggregate data on the episodic use of health services by patients with chronic and complex conditions (including long-term users of outpatient services) to aid in designing future episodic payment arrangements for these groups; and

- to better understand existing shared care models that cross public and private medical and other services (including models operating out of public hospital outpatient services) to foster the spread of evidence-based shared care models more broadly.

While there are significant implications of our recommendation for the Commonwealth Government to fund public hospital outpatient services, we focus here on the impact of the changed responsibility for primary health care services.

Our recommendation for **the Commonwealth Government to assume responsibility for state-funded primary health care** (such as community health centres and family and child health services) will require the government to confront the issue of how to integrate these services with medical services now funded under the MBS. We need to be clear that 'integration' does not mean 'takeover'. Nor does it mean that the Commonwealth Government would directly operate these services. We value the social health model of care that drives the provision of many state-funded primary health care services. And we are committed to the emphasis on population health and early intervention of many of these services.

We anticipate that the Commonwealth Government would need to spend some considerable time doing the equivalent of a 'stocktake' or a 'due diligence' exercise to better understand the range of primary health care services now provided by states outside of Medicare. For example, it will need to understand: the scope of services and how they differ between states; the current eligibility rules and any patient co-payments for accessing these services; and the remuneration and employment arrangements for health professionals employed in these services.

Ultimately, the Commonwealth Government will need to develop a national plan for integration of these services with existing MBS services. In doing so, it will need to make decisions about what additional primary health care services could be included as part of an expanded 'universal service entitlement' and the conditions under which this would operate. We are aware that state-funded primary health care services operate quite differently across jurisdictions. Many of these services are targeted to specific populations; some operate with co-payments; and there may be significant differences in access to these services across geographic regions. So, the Commonwealth Government would need to determine what service models it wanted to encourage and fund, potentially allowing for local innovation including the option of different services and service models for, say, rural communities and metropolitan suburbs. There are also some real challenges in moving to a 'national health system', given the existing differences across jurisdictions in the range and volume of state-funded primary health care services.

It is also unclear about the extent to which there is currently much communication, networking or cross-referral of patients between private medical practices and state-funded primary health care services. For example, it is unknown whether patients requiring access to allied health services under the Enhanced Primary Care component of the MBS ever use 'public' allied health services.

The Commonwealth Government would need to determine the basis on which it funds the existing state-funded primary health care services. We are not advocating that these services simply be included under the MBS on a fee-for-service basis. Paying for these services could involve a mix of salary, fee-for-service, grants, payments for performance and quality, and payments for episodes of care. While we have mainly discussed the existing state-funded primary health care services, we should be clear that we expect that **the Medicare Benefits Schedule will operate much as it does now for most people visiting their general practitioner for a one-off condition**. Medicare will continue to pay benefits to people to reimburse the cost of medical services under a fee-for-service schedule. As we indicated in Table 4.1, we expect that this will be complemented by other funding arrangements. We discuss our views about the evolution of funding models under the MBS later in this report (see Section 5.4.1).

We are aware that some governments are understandably cautious about the magnitude of the change in bringing existing state-funded primary health care services under the policy and funding responsibility of the Commonwealth Government. To achieve success in this endeavour will require effective collaboration and consultation between all governments and across health professions. It will require the Commonwealth Government to develop experience and knowledge across the whole spectrum of primary health care services. But these reforms must go ahead if we are to create an integrated primary health care platform for our entire health system.

4.3.3 Reviewing the scope of services under Medicare

During the lifetime of our review, we have received many submissions and spoken to many groups that argued that the MBS should be 'opened up' to pay for the services of other health professionals.

Framing the debate about opening up the MBS to other health professionals in the context of our recommendation for integration of state-funded primary health care services and private medical practice creates a very different starting point and dynamic.

It means, among other things, that our vision challenges the prevailing orthodoxy that assumes that including other health professionals on the MBS would necessarily involve fee-for-service payments and that these services would be provided by 'private' practitioners. In the future, the 'Medicare Benefits Schedule' would not necessarily be limited to a 'schedule' listing 'benefits' for particular professional services. As we indicated in Table 4.1, it could involve very different payment arrangements for a broader range of health services provided by a mix of public and private providers. It is in this context that we now outline our recommendations about expanding the scope of services that might be 'included' under Medicare.

Rethinking the universal service entitlement

Our starting point is that making decisions about including services under Medicare is inherently a political decision about redefining the 'universal service entitlement' – that is, what health services the Commonwealth Government believes should be funded (at least, in part) from public monies. There is no single 'right' answer to this question.

We have recommended that the **scope of the universal service entitlement** (which currently covers public hospitals, medical and pharmaceutical services) **should be debated over time to ensure that it is realistic, affordable and fair and will deliver the best health outcomes**, while reflecting the values and priorities of the community.

One element of this community debate about the universal service entitlement is creating greater transparency and public understanding about spending on health. We currently live in a 'magic pudding' world.¹⁵⁷ We 'see' that 1.5 per cent of our taxable income goes toward the 'Medicare Levy', yet many people do not realise that governments spend much more than this amount on health services. Being open about how much it costs to pay for our universal service entitlement for health services – and also understanding how much individuals contribute out of their own pockets – is an important step in a community debate about health spending. This public conversation needs to incorporate a broad range of views including consumer, clinical and economic perspectives.

The concept of the universal service entitlement is closely linked to the complex issue of health system financing – who should pay and how much for what health services. Our recommendations on this issue attempt to balance a number of competing pressures:

- Australia, like most other countries, relies on a mix of public and private financing to pay for health services. Private financing provides people with greater personal health care choices, while public financing offers the advantage of equity in de-coupling the need for health care and the ability to pay for health services;
- individual households already make substantial direct co-payments for health services. In 2006–07, direct payments by individuals accounted for \$16.0 billion or 17.0 per cent (one in six dollars) of all spending on health services;¹⁵⁸ and
- but there are very different spending patterns across different types of households and for different types of health services. The highest individual co-payments are made for services that are outside the 'universal service entitlement' of public hospitals, medical and pharmaceutical services. (We have earlier recommended expanding the universal entitlement to include access to basic preventive and restorative dental services).

¹⁵⁷ In Norman Lindsay's classic children's story, the magic pudding was unlimited in supply and could never be exhausted: 'A peculiar thing about the Puddin' was that, although they had all had a great many slices off him, there was no sign of the place whence the slices had been cut'.

¹⁵⁸ Australian Institute of Health and Welfare (2008), *Health expenditure Australia 2006-07* (Australian Institute of Health and Welfare: Canberra).

To retain the benefits of mixed public-private financing, we have recommended that the overall balance of spending through tax, private health insurance and co-payments be maintained over the next decade. However, we want to stress that this does not mean that we should not vary the mix of public and private financing for particular types of services.

We have recommended that **the scope and structure of safety net arrangements be reviewed**. There are currently multiple safety nets (covering, for example, the MBS (the original and extended Medicare safety nets¹⁵⁹), the PBS, and a net medical expenses tax rebate). In addition, there is a patchwork of government programs that partially meet the costs of some services (diabetes equipment, continence aids, therapeutic appliances). The purpose of reviewing safety net arrangements is to create a simpler, more family-centred approach that protects people from unaffordably high co-payments for using health services. In saying this, we are essentially acknowledging the need to recognise and tackle the high costs faced by some people for health services which fall outside our current universal service entitlement.

Hence, the 'flip side' of the safety net discussion is about how the Commonwealth Government decides whether and how to extend the universal service entitlement. There have already been steps towards recognising (and funding under the MBS) the complementary roles of some other health professionals. Some allied health services are now paid for under the MBS, while some general practices can receive grants towards employing a practice nurse with the ability to access a range of practice nurse specific items on the MBS. Flowing from the recent Maternity Services Review, the Commonwealth Government's 2009–2010 Budget announced that the services of eligible midwives would be covered under the MBS for the first time to provide greater access to care provided by midwives working in collaboration with doctors. The Budget also included funding for an expansion of services provided by nurse practitioners, including access to the MBS and PBS.

4.3.4 Reshaping the Medicare Benefits Schedule

Until now, we have been discussing the **broad evolution of the 'next generation' of Medicare**, with the Commonwealth Government having policy and funding responsibility for existing state-funded primary health care services, outpatient services and private medical services under the MBS.

We turn now from this broad discussion to consideration of **reshaping of the Medicare Benefits Schedule** – which forms one element of the 'next generation' of Medicare.

Moving to a greater focus on competency

The starting point for reshaping of the MBS is decisions by the Commonwealth Government about the scope of services that could be included under the MBS.

Flowing from such decisions, our recommendations on the MBS are grounded in a framework that **defines the competency and scope of practice** within which health professionals can provide certain services.

Core to our thinking of ensuring quality while expanding access to the MBS has been the better use of our diverse, skilled workforce. This involves the issue of competency and whether particular types of health professionals are competent to provide particular services. These elements are inextricably intertwined like the strands of DNA. We are not suggesting for one moment that we simply move to accept all services provided by certain health professionals as eligible for funding under the MBS. The assessment of competency is integrally tied to the 'approved' scope of practice for a particular set of services.

In formulating our recommendations around competency, a particular challenge is that there is a mismatch between the ten health professions that will shortly be subject to national registration and the broader set of health professions that is already included under existing MBS payment arrangements. To cut to the chase, this means that we cannot simply rely on whether particular health professionals are

159 Centre for Health Economics Research and Evaluation (2009), Extended Medicare safety net review report, at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/Review_%20Extended_Medicare_Safety_Net/\\$File/ExtendedMedicareSafetyNetReview.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/Review_%20Extended_Medicare_Safety_Net/$File/ExtendedMedicareSafetyNetReview.pdf)

registered as the threshold for making decisions about competency. (This would automatically exclude the services of groups such as speech pathologists and dietitians that governments have not agreed for inclusion under national registration).

Our recommendations are therefore based on whether a health professional is registered and/or that they are 'recognised' and appropriately credentialled by a relevant certifying body. For example, the test currently used under the MBS for dietitians is that they must be an 'accredited practising dietitian' as recognised by the Dietitians Association of Australia.

The second issue relates to defining the 'scope of practice'. While registration might be thought of as defining a baseline level of competency, credentialing is about recognising a set of specialist skills and defining an extended scope of practice (or set of services) that an individual health professional is authorised to safely undertake. For example, the Australian Nursing and Midwifery Council issues competency standards for nurse practitioners and midwives.

We have also recommended that we want this reshaping of the MBS to occur in a way that supports continuity and integration of care through **collaborative team models of care** involving relevant specialists, general practitioners, and other primary health care practitioners.

Ensuring fiscal sustainability

In reshaping the Medicare Benefits Schedule, we have argued that:

- the scope of services that is included under the MBS will first need to be defined by the Commonwealth Government;
- this will be supported, and given effect, by a framework that defines the competency and scope of practice within which health professionals can provide certain services; and
- any expansion of the MBS to other health professionals should also promote continuity and integration of care through collaborative team models of care.

We have recommended that the Commonwealth Government should continue to apply existing processes to ensure that the inclusion of services on the MBS is driven by a robust evidence base. This means that all 'new' services (whether provided by medical practitioners or other health practitioners) should be subject to the same rigorous approval processes to ensure that there is clear evidence about their safety, effectiveness and cost-effectiveness. We believe that this is vital to ensuring the financial sustainability of the MBS. A forward-looking approach would also build in regular review and evaluation of new services (say, after three years) under the MBS to ensure that they were meeting policy objectives.

We would also expect that the Commonwealth Government would seek to control the level of its spending under the MBS through a range of strategies. Some potential approaches that the Commonwealth Government might use include:

- it could control and limit the specific services that are included under Medicare for payment purposes;
- it could limit the organisations it recognises as relevant credentialing or certifying organisations for the purposes of paying for health services under the MBS. (This does not impact on the autonomy of such organisations to undertake credentialing, but relates to their recognition under the MBS for payment purposes). This could occur in a phased way with tight initial restrictions during which the impact on MBS spending is monitored; and
- at the level of individual services, the Commonwealth Government could introduce a range of controls around patient eligibility and provider eligibility.

The financial implications of reshaping the Medicare Benefits Schedule are potentially significant. While our recommendations provide a transparent framework for moving in this direction, we recognise that this must occur in a carefully regulated and phased manner.

In conclusion, we argue that this reshaping of the MBS is both required and inevitable, but it will need to occur in a phased way and be strongly driven by evidence.

CHAPTER 5

CREATING AN AGILE AND SELF-IMPROVING HEALTH SYSTEM



5. Creating an agile and self-improving health system

Our third major tranche of reforms is about how we can create a continuous culture of reform through building a health system that is ‘agile’ and ‘self-improving’.

Over the last quarter century, Australia has seen two other major health reform inquiries, such as this one.¹⁶⁰ Both included broad community debate about the sustainability of our health system, the production of expert reports, and the subsequent implementation of some reforms which ‘re-set’ our health system on a new course for the next ten or fifteen years. While this ‘episodic’ model has some advantages, we believe that it is also important to embed a culture of ongoing reform as an intrinsic feature of a sustainable health system, bringing the same culture of ‘continuous improvement’ to the system level, as we wish to encourage at the service level.

What do we mean by an agile and self-improving health system?

‘Agility’ has been described as a vital attribute in a ‘world of constant and sometimes rapid change’, driven by the need to respond to ‘complex problems in an uncertain environment’.¹⁶¹ Certainly, the Australian health system meets this description. It is dynamic, exposed to global economic trends, fads and fashions in health system design¹⁶² and international migration of new health care technologies, treatments and management ideas. Agility also suggests the concept of being ‘light on one’s feet’ in being able to respond quickly as circumstances change.

When we talk about a ‘self-improving’ health system, we are thinking of a health system that learns, creates and uses new information wisely, and is driven by innovation and continuous quality improvement. The important concept is that the ‘seeds of reform’ or self-improvement are built into the core of the health system. Reform is thus a continuous process that is owned and driven by the people who use and work in the health system, not a once in a decade ‘set and forget’ approach.

We believe that many of our reform recommendations fall into this category of creating an agile and self-improving health system. In this chapter, we have grouped these reforms under five levers for action, as follows:

1. Strengthened consumer engagement and voice;
2. A modern, learning and supported health workforce;
3. Smart use of data, information and communication;
4. Well-designed funding and strategic purchasing models; and
5. Knowledge-led continuous improvement, innovation and research.

These levers are about governments (and others) creating the right ‘architecture’ for our health system. As we explained in Chapter 2, we expect that once we get the architecture for health system reform right, reform can be ‘everybody’s business’ and we can move to a health system that is agile and self-improving.

We now turn to identifying our reform recommendations under each of the five levers for action. We begin with the two levers related to our most important resource – the people who use our health system and the people who work in our health system.

5.1 Strengthened consumer engagement and voice

From Day One, we have said that the first and most important principle guiding health reform is that it must be ‘people and family-centred’. We use the term ‘people’ broadly and inclusively. People includes

¹⁶⁰ These two inquiries were the National Health Strategy in the early 1990s and the Commission of Inquiry into the Efficiency and Administration of Hospitals in the early 1980s. While not an inquiry, the Whitlam-era National Hospitals and Health Services Commission also provided a major reset of the health system, being notable particularly for the introduction of the Community Health Program.

¹⁶¹ G Gallop (2007), Agile government, Paper presented at the Agile Government Roundtable, State Services Authority, Melbourne, 11 October 2007.

¹⁶² T Marmor (2004), Fads in medical care management and policy: Rock Carling Fellowship (The Nuffield Trust: London).

individuals, their families, carers, advocates and communities; and it extends to the many roles we have, whether as 'consumers', 'patients' or 'citizens'.

The principle of 'public voice and community engagement' is a separate, although obviously related, dimension of a people-centred health system. We believe that the health system of the future should be organised around the integral roles of consumer voice and choice, citizen engagement and community participation. This is about giving people real control and choice about whether, how, where and when they use health services, supported by access to evidence-based information that facilitates informed choices. It is also about ensuring that the experience and views of consumers and whole communities are incorporated into how we redesign and improve health services in the future.

Through our consultations and submissions, we heard strong support for strengthening consumer engagement and voice in our health system:

“ Actively creating space for the public to be heard not only allows a rich source of information on the patient journey and experience to be gathered, but is also a way for the system to recognise the value of the contributions that patients, carers and the community can make. The consumer voice is essential to full understanding about how to build a safe and quality health system.¹⁶³

“ Consumers should not only be the focus of the health system, they should be at the centre of decision-making in health. Both at a policy level and an individual level, consumer experiences and preferences should help lead health system reforms, alongside the evidence base. The reality of shared responsibility requires not just declaring it but building consumer health literacy and access to quality information and advice.¹⁶⁴

5.1.1 Improving health literacy

However, we know that about 60 per cent of Australians are not able to effectively participate (exercise their 'choice' or 'voice') as they lack basic health literacy. That is, they lack the knowledge and skills to understand and use information about how to stay healthy or how to find their way around the health system. There is also clear evidence that lower health literacy can result in poor outcomes. People with poor health literacy have lower rates of screening for preventable health conditions, poorer experience in managing the health of their children, and difficulty in following instructions from their health care practitioner.¹⁶⁵

Accordingly, we have recommended that **health literacy be included as a core element of the National Curriculum** and incorporated in national skills assessment, applying across primary and secondary schools. Getting good information to our children is an effective way to boost our population's health literacy.

We have also proposed targeted approaches to **improving health literacy in particular domains, such as mental health literacy**. For too long, people with mental illness have been stigmatised. We are recommending a sustained national community awareness campaign to tackle this issue. More generally, we believe that it is vital that governments, private health insurers, health services, non-government organisations and the media all contribute to improving health literacy among the general population. **Helping people to 'make healthy choices easy choices'** has to apply at all ages and across all groups in our population.

¹⁶³ Australian Commission on Safety and Quality in Health Care (2008), Submission 428 to the National Health and Hospitals Reform Commission: First Round Submissions.

¹⁶⁴ National Prescribing Service (2008), Submission 431 to the National Health and Hospitals Reform Commission: First Round Submissions.

¹⁶⁵ Agency for Health care Research and Quality (2004), Literacy and health outcomes: Evidence report/Technology Assessment No. 87, at <http://www.ahrq.gov/downloads/pub/evidence/pdf/literacy/literacy.pdf>

5.1.2 Fostering genuine participation

Of course, people need more than just the right information if they are to be active participants in shaping the health system. We need to **have robust processes that promote and value the participation of the community** in a meaningful, non-tokenistic way. We have recommended that there needs to be systematic use of mechanisms that allows the identification of different views – consumers, clinicians, managers, funders and others with a stake in the health system. **Citizen juries** are one approach to encouraging genuine deliberation on tough issues, such as how to allocate scarce resources among competing priorities.¹⁶⁶ We agree with the views articulated in one of our submissions:

“Successful reform is more likely if governments engage communities openly and honestly and if the reform process is a two-way street, with governments listening carefully to the views of patients and providers.”¹⁶⁷

Listening to the views of the community on health reform must be an ongoing commitment backed up by a robust process, which transcends the lifespan of short-term inquiries such as this one. We return to this issue in Chapter 7 where we outline the need **for routine monitoring of the views of consumers and clinicians about their confidence in the health system**.

Participation is also vital at a regional level, so that communities can influence and shape the way in which local health services are delivered. In particular, we know that many parts of rural Australia struggle to cope with multiple funding programs for health services that do not meet the needs of their local communities. For some of these communities, it is like the proverbial ‘square peg in the round hole’. There are multiple health ‘programs’, each with different eligibility criteria and guidelines, but these programs do not match what is actually required at the local level. We heard:

“Reform should build on service models that support flexible, integrated and sustainable service delivery to small communities. It should allow a community to improve the range of services offered locally, by integrating funding streams, co-locating services and creating supportive viable workforce conditions.”¹⁶⁸

To make it easier for local communities to shape and get the right health services for their needs, we have recommended the use of **flexible funding models in some remote and rural communities**. This includes top-up funding (‘equivalence payments’) for primary health care services (earlier described in Section 3.2.5) and an expanded use of the so-called ‘multi-purpose service’ model. This allows small remote and rural towns (of about 12,000 people) to ‘cash out’ funding from multiple health and aged care programs that are now funded by the Commonwealth and state and territory governments. The pooled funding would then be used to allow health and aged care services to be more flexibly designed around the needs of local communities.

5.1.3 Becoming ‘extremists’ on patient decision-making

Donald Berwick, the American guru of quality in health care, recently challenged his fellow health practitioners to adopt some radical, and uncomfortable, ideas about what ‘patient-centred’ care should really mean.¹⁶⁹ For example, he suggests that evidence-based medicine ‘sometimes must take a back seat’ if clinicians are truly to respect the wishes of patients. And that ‘non-compliance’ legitimately reflects the different values and priorities that individuals have in their lives, as well as highlighting the challenge of better information exchange between clinician and patient.

¹⁶⁶ GH Mooney and SH Blackwell (2004), ‘Whose health service is it anyway? Community values in health care’, *Medical Journal of Australia*, 180 (2): 76-78.

¹⁶⁷ Australian Medical Association (2008), Submission 445 to the National Health and Hospitals Reform Commission: First Round Submissions.

¹⁶⁸ Rural Doctors Association of Queensland (2008), Submission 499 to the National Health and Hospitals Reform Commission: First Round Submissions.

¹⁶⁹ D Berwick (2009), ‘What ‘patient-centred’ should mean: Confessions of an extremist’, *Health Affairs*, Web exclusive, published online, 19 May 2009. See also: P Chen (June 009) Letting the patient call the shots, *New York Times*, 4 June 2009, at: http://www.nytimes.com/2009/06/04/health/04chen.html?_r=3&ref=health

While we have moved a long way from the 'doctor knows best' philosophy typified by the 1960s Doctor Kildare television series, we are still some distance from a health system that genuinely lets patients 'call the shots'. **Empowering consumers to make fully informed decisions** is an important element of this shifting power balance between consumers and clinicians. For example, we **recognise and support the increasing development of 'decision aids'** that can be used to help patients make better informed decisions, incorporating their values and preferences about health treatment choices.¹⁷⁰

We also acknowledge the **vital role of informal and family carers** in supporting people in their use of health care services. Decision-making often involves more than the individual 'patient', so we have recommended that carers be supported through educational programs, mentoring and timely advice to allow them to participate in health decisions and communications (subject, of course, to the consent of those they care for). To sustain them in this role, carers must have better access to respite care.

One area where it is particularly important to give people more control relates to their decisions when they are dying. We know that for some dying patients and their families, the time of dying can be a chaotic experience with people transferred on an emergency basis to hospitals and receiving some treatments that may do little to improve their quality of life. Of course, what some people may consider to be 'heroic' treatment, other people would steadfastly insist should be provided to prolong their life. There are no hard and fast rules. This should be about individual choices, made in consultation with families and carers, but ultimately grounded in respecting people's wishes about their dying.

We have recommended a national approach to funding and implementation of **advance care planning** to support people making informed decisions about their dying.¹⁷¹ We have suggested that this should commence in residential aged care services (and then be made available to other relevant populations). There is clear evidence that when older people living in residential aged care services participate in developing an advance care plan, they are much less likely to be transferred to, and die, in hospital.¹⁷² The implementation of advance care planning should include the provision of **suitable training for the health and aged care workforce**. We have also recommended that there be better education among health professionals of the common law right of people to make decisions about their medical treatment, including the right to decline treatment.

5.2 A modern, learning and supported health workforce

We believe that our health system should seek to optimise the dedication, diversity, energy and dynamism of our health workforce. Australia has a world-class approach to the education and training of this workforce. The people who care for and treat us comprise one of the major strengths of our health system. Our health workforce is responsible for the enviably high standard of health care that we enjoy in Australia. They are key agents of change, reform and innovation, driving continuous improvement in the delivery of health services at the coalface. And they are essential in monitoring whether our health system is achieving on its purpose of delivering better health outcomes for people. Accordingly, we want **health system reform to be integrally shaped by the experience and knowledge of our health workforce**, including clinicians and health system managers.

5.2.1 Valuing the expertise of, and supporting, our health workforce

There is a real need to improve the engagement of the clinical workforce in guiding and influencing the management and future directions of health reform. We heard often through our consultations and submissions that many health professionals felt disenfranchised and undervalued, while health service managers were under pressure and poorly supported. This situation needs action on multiple fronts.

170 There has been considerable development in the United States of 'shared decision making' through the use of 'decision aids'. This approach is being used for what are termed 'preference-sensitive' decisions which involve patients making value-based judgments about the benefits and risk of particular treatment options to them as individuals. Examples might include decisions about treatment options for an enlarged benign prostate, lower back pain, osteoarthritis of the knee or non-invasive breast cancer. See: A O'Connor et al (2007), 'Toward the 'tipping point': Decision aids and informed choice', *Health Affairs*, 26(3): 716-725; 10.1377/hlthaff.26.3.716.

171 An advance care plan allows people to identify on a step-by-step basis how they want their symptoms managed and their treatment preferences.

172 An evaluation of one approach to advance care planning (the Respecting Patient Choices program which was initially implemented across 17 residential aged care services and two palliative care services) found that 85 per cent of people with an advance care plan were able to 'die in place' in their aged care service, while 67 per cent of people without an advance care plan were transferred to, and died, in hospital. See: W Silvester and colleagues (2008), Submission 18 to the National Health and Hospitals Reform Commission: First Round Submissions.

That is why we have recommended a comprehensive suite of strategies to better support our health workforce. This includes the establishment of better participatory and consultative mechanisms to build genuine clinician engagement including '**Clinical Senates**' at national, regional and local levels, as well as taskforces on particular issues. Clinical Senates already operate in several states and are used as a forum for clinical leaders to share their 'knowledge, provide advice, leadership and guidance on clinical issues and participate in the decision making process in relation to clinical service planning'.¹⁷³ For example, in Western Australia, the Clinical Senate has contributed to shaping the debate and decisions on improving end of life care, strengthening population health, and closing the life expectancy gap among Aboriginal and Torres Strait Islander people.¹⁷⁴

We have also recommended regularly undertaking **health workforce opinion surveys** so that we can listen and learn about what needs to be improved to make our health system work better.

Improving the morale and satisfaction of our health workforce also requires a genuine commitment to supporting them in their work. For example, we believe that **workplace health programs** for people working in the health sector should become the 'gold standard' and set the benchmark for encouraging a healthy workplace. The health of our health workforce has, too often, been relegated to the bottom of the list in making decisions about the organisation and funding of health services. This is not sustainable. We are already struggling to recruit and retain a skilled workforce for our health system, so we must invest adequately in keeping them healthy and safe while they are contributing to keeping us healthy and safe.

At a national level, we have called for a systemic approach to **encouraging, supporting and harnessing clinical leadership** across all health settings and across different professional disciplines. This includes promoting a continuous improvement culture by providing opportunities for clinicians to participate in teaching, research and quality improvement processes across all health service settings.

Clinical governance – the framework through which health services are accountable for the health outcomes they deliver – must be strengthened. Effective clinical governance requires clinical leadership and ownership with a broad culture of clinician engagement so that health practice is always based on the best available evidence, with continuous improvement driven by smart data and critical appraisal. This needs to be supported through investment in management and leadership skills development for clinicians and managers across the health system. Effective clinical governance is one vital element in retaining our health workforce. We believe that health services need to promote a culture of mutual respect and patient focus for all health professions through shared values, management structures, compensation arrangements, shared educational experiences, and clinical governance processes that support team approaches to care.

Health service leadership requires **bringing together clinical and corporate accountabilities** to both the community served and governments, in order to create an environment in which health professionals can deliver optimal services to their patients. We believe that systems must be developed to support health service managers with the active engagement of clinical leaders. Communication, respect and collaborative decision-making between health service managers and clinical leaders are vital.

5.2.2 Planning and educating a modern health workforce

While Australia has a highly qualified health workforce, there is, nonetheless, room for improvement in how we plan for, and educate, our next generation of health professionals.

The **planning of our future health workforce requirements** is a bit like Swiss cheese (riddled with gaps and incomplete and poorly coordinated information). Meanwhile, the education of our health workforce still tends to reinforce professional boundaries and does not adequately foster team-based collaborative models of care. There is growing support to strengthen and redesign how we train our health professionals. Some of our submissions challenged our current models for training health professionals and delivering health services:

¹⁷³ Information about the role of the South Australian Clinical Senate, at: <http://www.health.sa.gov.au>

¹⁷⁴ Information on the Western Australian Clinical Senate is at: <http://clinicalsenate.health.wa.gov.au/home>

“ Efforts should also be made to improve inter-professional learning across the health professions...Inter-professional learning is seen as a particularly effective way of meeting contemporary health care needs through its capacity for developing interdisciplinary teamwork; improving collaboration between the professions and the patient; increasing the workforce skill mix; and supporting innovative work practices.¹⁷⁵

“ As part of health care reform, breaking down the legislative and professional barriers to enhance the professional role of nurses, nurse practitioners and other allied health workers is an important issue, and one that needs addressing. Making the patient ‘the centre of care’ needs more than rhetoric and access to professional health care by the community is a basic right, not something that is to be restricted due to territorial disputes, or a view that the patient belongs to any particular primary health carer.¹⁷⁶

These issues are well documented and have been the subject of numerous inquiries, including by the Productivity Commission in 2005.¹⁷⁷

Our recommended reforms include the development of **a new framework for the education and training of our health professionals** which:

- moves towards a flexible, multi-disciplinary approach to how we educate and train health professionals; and
- incorporates an agreed competency-based framework as part of a broad teaching and learning curriculum for all health professionals.

Our Interim Report generated considerable debate on the issue of **competency-based training**. We want to clarify that we fully recognise that a competency-based framework is not the whole story when it comes to the training of our health professionals. We agree with the sentiments articulated in several submissions including as follows:

“ While the adoption of a competency-based framework is supported it is stressed that not all graduate attributes can be reduced to competencies. While knowledge and understanding and skills attributes can be expressed as competencies, this is more difficult for attitudes and behaviours and other assessment and evaluation methods for these must be utilised. However, there will be considerable benefit in developing a competency-based framework for medical education where this can be achieved.¹⁷⁸

175 Australian Nursing Federation (2008), Submission 313 to the National Health and Hospitals Reform Commission: First Round Submissions.

176 Australian Primary Care Community Partnership (2008), Submission to the National Health and Hospitals Reform Commission: First Round Submissions.

177 Productivity Commission (2005), Australia's health workforce: Research report, (Commonwealth of Australia: Canberra).

178 A Carmichael (2009), Submission 99 to the National Health and Hospitals Reform Commission: Second Round Submissions.

We are also recommending a new approach to funding the education and training of our health workforce with a **dedicated funding stream for clinical placements for undergraduate and postgraduate students**. Funding should follow the students and be concentrated at supporting training in quality environments. Among other things, this must provide for **clinical training infrastructure to be available across all health settings** – public and private – including hospitals, primary health care and other community settings. This infrastructure should foster improved efficiency in providing education across the whole vertical training continuum in the same sites – through undergraduate and postgraduate.

Turning now to the issue of workforce planning, in our Interim Report we proposed the establishment of a **National Clinical Education and Training Agency**. At about the same time, the Council of Australian Governments announced that it had agreed to establish a national health workforce agency to drive a more strategic long-term plan for the health workforce.¹⁷⁹ While the precise details of the national health workforce agency are still being developed and are ‘under wraps’, we understand that there is likely to be considerable overlap with the functions we initially proposed for a new National Clinical Education and Training Agency. Of course, we would not be recommending the establishment of another national workforce agency in these circumstances. However, for the purpose of clearly delineating our views as to the desired functions and roles of such an agency, we are continuing to describe our proposals under the working title of the National Clinical Education and Training Agency. The functions which this Agency should take on include:

- advising on the education and training requirements at both a national and regional level, together with supporting the planning of clinical education infrastructure;
- purchasing, in partnership with universities, vocational education and training institutions and professional colleges, clinical education placements from health service providers. This would include using activity-based payments to pay for undergraduate clinical education and postgraduate training;
- promoting innovation in education and training, including as an aggregator and facilitator for the provision of modular competency-based programs for up-skilling of health professionals;
- fostering local implementation models and partnerships around educational teams; and
- reporting regularly on the appropriateness of professional accreditation standards.

We want this new workforce agency to drive innovation and improve collaboration, communication and planning between the health services and health education and training sectors. We have also affirmed **the value of national registration of health professionals** – a key component of moving to ‘one national health system’.

In summary, we believe that these recommendations on supporting planning and training will contribute to the agility of our health workforce and better position them to be agents for change in driving reform and promoting a self-improving health system of the future.

5.3 Smart use of data, information and communication

We want our future health system to be powered by the smart use of data and enabled by the electronic flow of essential information between individuals and the health professionals from whom they seek care and advice. There should be a passionate commitment to measure and improve health and performance outcomes with transparent reporting customised for all ‘users’ – consumers, health professionals, funders and governments. Data should enhance decision-making, drive improvements in clinical practice, guide how resources are marshalled and deployed and provide the basis for feedback loops to promote improvement in access to, and quality and efficiency of, care. A data rich environment should be the expectation across all health settings. Key to improvements in our health system of the future will be a structured, robust communication matrix that connects all participants with relevant, accurate and secure information in real-time.

¹⁷⁹ Council of Australian Governments (2008), COAG meeting outcomes, 29 November 2008, at: http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/attachments.cfm

The smart use of data is, and should be, at the very core of a self-improving system.

That is the vision. But the current reality is quite different. We heard about some of the problems with how our health system currently fails to make the best use of data:

“ Putting a young intern into a modern emergency department or intensive care unit with the current average level of systems support is like expecting a new graduate stockbroker to manage an intricate portfolio on today’s sophisticated financial markets with little more than a ball-point pen and a slide rule.¹⁸⁰

And we also heard about the potential that could be unlocked in the future:

“ An electronic medical record which incorporated a system of automatically checking for decision aids relevant to the patient’s diagnosis could enhance the use of decision aids, facilitating patient decision-making and shared responsibility for health.¹⁸¹

“ As we live longer, often with health conditions, the nature of information needed to support care is changing from episodic care delivered by individual providers to chronic disease management with multiple providers. Both these factors highlight a need for a different evidence base; one that is patient centred and follows the patient journey over time...Statistics are required on the way in which patients use the total health care system, not just on the numbers using a specific service at a particular point in time. It is important to know what happens, for example, as people move between acute hospital and rehabilitation care, residential aged care and community care, and what factors influence this movement.¹⁸²

Our recommendations on these issues are underpinned by the broad philosophy that we should optimise the smart use of data:

- **For all groups** – individuals (whether they are ‘patients’ or citizens), families and carers, health professionals, hospitals, private health insurers, employers, communities and governments;
- **Across all health settings** – hospitals, primary health care, public and private services – as well as in ‘non-health’ settings such as workplaces and local communities; and
- **For multiple policy objectives** – to improve the safety and quality of health care; to better connect and integrate care for people; to facilitate effective self-management; to foster multidisciplinary team-based care; to drive continuous quality improvement; to achieve better health outcomes; to promote effective resource-allocation; to ensure accountability and transparency; to promote consumer choice and responsiveness in our health system; to drive research; to improve system performance and understanding; and to monitor the progress of health reform.

180 Cerner Corporation (2008), Submission 61 to the National Health and Hospitals Reform Commission, First Round Submissions.

181 L Condon (2008), Submission 413 to the National Health and Hospitals Reform Commission: First Round Submissions.

182 Australian Institute of Health and Welfare (2008), Submission 8 to the National Health and Hospitals Reform Commission: First Round Submissions.

5.3.1 Giving people control over their own health information

In our Interim Report, we argued that **the introduction of an electronic health record for each Australian** was one of the most important systemic opportunities to improve the safety and quality of health care, reduce waste and inefficiency, and improve continuity and health outcomes for patients. Our supplementary report, *Person-Controlled Electronic Health Records*, outlined our views on how to achieve this goal. (We need to be clear that this was not an attempt to espouse a complete vision for e-health for Australia, but only part of the picture. Since the release of these reports, we have undertaken further work on e-health and these issues are discussed next in Section 5.3.2).

In this section, we focus on the introduction of a person-controlled electronic health record.¹⁸³ This approach is driven by our most important principle of striving to achieve a person-centred health system. Giving people better access to their own health information through a person-controlled electronic health record is absolutely essential to promoting consumer participation, and supporting self-management and informed decision-making.

Our recommendation is that, by 2012, every Australian should be able to have a **person-controlled electronic health record**. This involves people being able:

- to control access to their own health information (including what information they will share with health practitioners);
- to add information relevant to self-management and healthy lifestyles (such as home monitoring of blood pressure or diabetes control); and
- to choose where and how their health record will be stored, backed-up and retrieved.

We know that the concept of patients controlling access to their own health information may be confronting to some health practitioners. Our response to this is two-fold. First, a person-controlled electronic health record is only one part of the broader e-health environment. It does not remove the need for ongoing development of electronic health records by health services, including strategies to join up and integrate information across the care continuum. Second, patients have always had the right to choose whether or not to share some or all of their information with health professionals they consult (and some patients may choose to access different practitioners at different times because of the sensitivity of some health information) – this occurs regardless of whether we are living in an ‘e-world’ or relying on other forms of communication.

To ensure optimal health care and outcomes, it will be important to ensure that information on the person-controlled electronic health record is accurate and from a verifiable, trusted source. A person’s own notes (and those of their carer) are important and termed a ‘respected’ source and must also be verifiable. This information all needs to be clear about who has entered data (the provenance of this data) so that a clinician viewing the record, with the patient’s consent, can rely upon the information in caring for that patient. For example, the source of a pathology result or a medication order would need to be authenticated to be relied upon. There are significant benefits for better and more efficient health care offered by having a personal health record, such as not having to duplicate tests and avoiding medication errors and interactions. If the patient authorises health professionals to access their record, the patient will also be able to see an audit trail indicating who has added to or viewed the record.

Our proposal for a person-controlled electronic health record is underpinned by the philosophy that good communication is vital in health. But we know that the current lack of interoperability standards and the inability to send and receive even high quality data from one system to another, between and even within health care settings, should be addressed as a matter of urgency. We can’t even identify that a set of data is actually that of one person or another, as there are often many different identifiers for an individual in each service that they are treated. Hence, we have recommended the introduction of **unique personal identifiers and a set of nationally agreed and implemented standards** that would address the need for one system to talk to the other and provide information about the patient, whichever system is chosen to access and record their treatment on.

¹⁸³ There are many different concepts and terminologies used in discussing electronic health records. These include: individual electronic health record, shared health record, electronic medical record and person-controlled electronic health record. Our report on *Person-Controlled Electronic Health Records* distinguishes between these concepts. As we made clear in that report, our interest is in a person-controlled electronic health record, which we define further in Section 5.3.1

We are recommending that the Commonwealth Government legislate to **ensure the confidentiality and privacy of a person's electronic health data**, while enabling secure access to that data by health practitioners (who have been authorised by the person to view relevant data on the record). Our recommendations are based on the Commonwealth Government taking **a leadership role in clearly stipulating the required 'architecture' for electronic health records** (including unique identifiers for patients, health professions and health service organisations, authentication systems, and rules to optimise interoperability of systems).

There are several other important roles for the Commonwealth Government detailed in our recommendations including:

- mandating that payments for health and aged care services will be dependent on the ability to provide data to patients for integration into a personal electronic health record and to accept data from other health providers electronically within stipulated timeframes; and
- implementing a **national social marketing strategy** to inform consumers and health professionals about the significant benefits and safeguards of the proposed e-health approach. The need to build understanding and achieve 'buy-in' from consumers, health professionals and health system managers must be a priority and is a matter of winning 'hearts and minds'.

We believe there are a number of potential funders of an individual's access to a person-controlled electronic health record. These might include people and families themselves, health funds for their members, and employers for their employees. Governments would have an important role in ensuring those with the greatest need have ready access to a record.

5.3.2 Enabling an e-health environment

E-health is the combined use of electronic communication and information technology in the health sector. The widespread adoption of e-health is vital to driving safety and quality in health care. However, health information and communications technology (ICT) alone will not dramatically improve care and reduce costs. Even when information is electronic it is not always freely shared across organisational boundaries due to multiple constraints and barriers.

To realise the benefits of health ICT we must enhance the free flow of health information and communications among patients and health professionals throughout the country, and act now to realise the vision of a patient-centred health system. We believe that taking action to put in place the architecture and environment to enable individuals to have, hold and control their own electronic record is a critical step, as has already been discussed.

Achieving a 'liquid' flow of essential health information among health professionals and between health professionals and their patients is complex. In Australia, attempts have been fragmented and fraught with difficulty. Much like the state and private railways of the 19th century, Australia runs the risk of un-linked electronic health infrastructure. There are already significant pockets of investment in electronic health data and information exchange across Australia. From remote communities to metropolitan hospitals, governments, private companies and clinicians have implemented dozens of innovative e-health projects. But much more can be gained by taking advantage of synergies and committing to a truly national effort to optimise the system.

Accelerating the implementation of a national policy framework

Like many other developed countries, Australia has long recognised the important enabling role of e-health in achieving health system reform, and embarked on key initiatives in the early 1990s. The momentum increased with the creation of the intergovernmental National E-Health Transition Authority (NEHTA) in 2005. We recognise and acknowledge the considerable work already undertaken by governments through the National E-Health Transition Authority. This includes the development of the National E-Health Strategy¹⁸⁴ and the decision by governments in 2008 that all Australians would be allocated a unique health identity (an individual health care identifier).¹⁸⁵

184 Australian Health Ministers' Conference (2008), National e-health strategy summary, December 2008, at: http://www.ahmac.gov.au/cms_documents/National%20E-Health%20Strategy.pdf

185 Australian Health Ministers' Conference (2009), Communique, 5 March 2009, at: http://www.ahmac.gov.au/cms_documents/AHMC%20Communique%20-%20Issued%205%20March%202009.doc

However, there is increasing frustration and mounting cynicism with the pace of action on implementing a national e-health platform. The lack of visible utility at the point of care has resulted in calls to stop the 'talkfest' and get on with setting a dedicated budget and definite delivery date with clear responsive and responsible governance for electronically enabling the health system: e-health.¹⁸⁶

There remains a small window of opportunity to capitalise now on the considerable investments in a national e-health system. Otherwise, Australia will incur a significant increased economic cost in the future to achieve a well-connected, useful and secure e-health system. We must also leverage what already exists by guiding the longer term convergence of local systems into an integrated but evolving national health system by ensuring that:

- the national policy framework **incorporates open technical standards which provide for interoperability, compliance, confidentiality and security**; and
- these standards are developed with the **participation and commitment of state governments, the ICT vendor industry, health professionals and consumers**.

This framework will be essential to the development of interoperable 'feeder systems', which will provide key data to populate the person-controlled electronic health record irrespective of the supplier of the system.

We are also recommending that the Commonwealth Government take the lead to ensure internet connectivity for all Australians. **A national broadband and telecommunications network** is essential to allow the secure transfer of health information, whether voice, data or images (including videoconferencing), to the point of care. This will be particularly important in remote and rural Australia and will make possible the use of emerging technologies such as home monitoring and the use of data to enhance self-care, as well as providing access to health information and advice portals.

A 'middle-out' approach to e-health in Australia

A 'middle-out approach' – charging government with national responsibility for creating a common set of technical goals and underpinning standards that can sit between them – is considered by some a better approach than a 'top-down', big procurement approach to national health information systems.¹⁸⁷

With some core public interest exceptions, especially around safety, privacy, and consent legislation, the pact that government makes with local institutions is that, beyond its commitment to common goals and standards, it will not try to shape what is done locally.

However, standards development and, where necessary, support for standards implementation, still requires a considerable financial commitment from government. Our recommended reforms build upon the National E-Health Strategy Summary published late last year by the Australian Health Ministers' Conference, but urge the Commonwealth Government to take responsibility for accelerating and adequately resourcing implementation of a National E-health Action Plan which:

- incorporates strengthened **national leadership** to direct and revitalise implementation and which values and actively seeks the expert guidance of key stakeholders;
- provides **support to public health organisations and incentives to private providers** to augment uptake of compliant e-health systems which enable provider-held electronic health records and facilitate the authorised exchange of professionally validated health information. This should not require government involvement with designing, buying or operating IT systems;
- drives collaboration by governments to resource **a national health knowledge web portal** (comprising e-tools for self-help) for the public and health practitioners. This could occur via the National Health Call Centre Network; and
- prioritises development of the national platform upon which **electronic prescribing and medication management systems** can operate in all health care settings.

186 For example: M B Van Der Weyden (2009) The e-health personal record, eMJA, 190 (7): 345

187 E Coiera (2009) Building a National Health IT System from the Middle Out, J Am Med Inform Assoc., 16: (3).

This is a responsibility that governments cannot step away from. In Australia, around six per cent of hospital admissions and 10 per cent of general practice patients experience adverse drug events. Particularly high medication error rates occur in the elderly and during transfer of care between hospital and community settings (it has been estimated that between 52 to 88 per cent of transfer documents contain an error).¹⁸⁸ Apart from the absolute need to minimise harm to patients, a national approach to enabling electronic transfer of prescriptions and safe management of a patient's medications at the point of care will reduce duplication, waste and system-wide inefficiency.

Supporting an ICT savvy health workforce

Encouraging health providers to 'get out of paper', particularly in the areas of prescriptions, laboratory results and medical imaging, requires a significant change in the way clinicians practise, as well as back room administrative processes. Rapid uptake of electronic information exchange, storage systems and decision support software will not occur unless our workforce has the relevant skills and are supported during the change management process.

To achieve this, we are recommending that governments recognise that they will need to **invest in e-health teaching, training and change management** in order to up-skill health professionals and managers to work in an electronically enabled health information environment.

We are also recommending that the number of **graduates with vocational and tertiary qualifications in health informatics will need to vastly increase** to meet the demands of a national e-health work program. Health care providers will also rely on expert staff to adopt standards-compliant e-health systems and to ensure secure information exchange with other providers and their own patients.

It is also the case that implementing many of our reforms around smart data and e-health will drive demand for experts in health informatics. They will be required to provide the knowledge base to classify and report on health activity and outcomes, source evidence based information, design and maintain health information portals, and support the implementation and evolution of electronic data interchange and storage.

The potential explosion in the use of telephonic, video and internet as the means to better connect patients with health professionals will further drive the demand for professionals skilled in the use of information and communication technologies.

5.3.3 Using information to promote better health and healthy communities

Access to good information is also vital to measuring and monitoring the health of our population. By definition, a self-improving health system must be able to measure whether it is, indeed, improving.

We are recommending the development of **Healthy Australia Goals** – a rolling series of ten-year goals – by which all Australians can participate in setting goals and working towards improvements in health outcomes at local, regional and national levels. These goals could become a 'rallying point' to foster greater community interest in how we are tracking on improving health outcomes for all Australians. Having measurable goals provides a powerful incentive to drive change. (Witness the attention given by the media to reporting on the capacity of our dams, and performance in meeting daily water consumption targets in some parts of Australia).

The first set of goals, Healthy Australia 2020, would be developed with broad community input and identify improvements we want to achieve over the next decade. For example, this might include turning the tide on the obesity epidemic, reducing teenage binge drinking rates, or reducing trauma and injury in our community. In the same way that communities 'adopt a road' to keep clean, we imagine

¹⁸⁸ National Prescribing Service Limited (2009), Medication Safety in the Community: A Review of the Literature.

that communities could also work to tackle health goals that are particularly relevant to them (whether this is in a workplace, a small rural community, a school, or some other group). For example, local councils might choose to improve walking paths and outdoor recreation spaces. There would be regular reporting on our progress so that we stay on track and celebrate successes along the way.

We are also recommending the development of information that measures the health of local communities. Some people have described this concept as the '**wellness footprint**' (echoing the term, our carbon footprint). For example, the Community Indicators Victoria website provides information on how communities measure up on child health assessments, use of public transport, personal health and wellbeing, school retention rates, and household affordability.¹⁸⁹ Information on health issues of particular concern to local communities is vital to promoting community engagement and participation.

5.3.4 Promoting a culture of improvement through health performance reporting

We have earlier described our proposal for the establishment of **National Access Targets** (see section 3.3). These targets are one approach to measuring and publicly reporting on whether our health system is delivering timely access to people across a broad range of health services. Like the Healthy Australia Goals we described above, the National Access Targets may evolve over time, responding to changing priorities of the community.

Providing data on all dimensions of our health system performance (not just access) is important at many levels. Our recommendations include:

- ensuring that we have systems in place to **provide comparative clinical performance data back to health services and hospitals, clinical units and clinicians**. This is essential to foster continuous quality improvement. (We frequently heard during our consultations about multiple data collection requirements on health services which disappeared into bureaucratic black holes with no useful data provided back to the health services). We support the use of benchmarking exercises that encourage health services to understand how they are performing relative to their peers (such as data generated through the Australian Council on Health care Standards, general practice accreditation and the Australian Primary Care Collaboratives Program¹⁹⁰);
- empowering the Australian Commission on Safety and Quality in Health Care to **analyse and report on safety and quality across all health settings**. We want a nationally consistent approach to the collection and comparative reporting of indicators which monitor safety and quality of care delivery. This should include not only 'clinical quality' measures, but, importantly, we are also recommending the development and conduct of regular **national patient experience surveys** and reporting on **patient-reported outcomes measures**. There has been considerable development of patient-reported outcome measures¹⁹¹ which capture the impact on quality of life of medical treatments (such as improvement in mobility after a knee replacement operation). Reporting on how consumers experience the health system and how they value the outcomes is essential to promoting an agile and self-improving health system;
- encouraging **public reporting** by hospitals, Comprehensive Primary Health Care Centres and Services, and residential aged care services through accreditation requirements on how they are progressing with **quality improvement activities and research**; and
- ensuring that we measure and report on how our health system is serving population groups who are likely to be disadvantaged in our communities. We have recommended **regular reporting that tracks our progress as a nation in tackling health inequity**.

189 Community Indicators Victoria, at <http://www.communityindicators.net.au>

190 The Australian Primary Care Collaboratives Program has seen participating general practices use the Improvement Model to generate better health outcomes for patients with chronic disease. See: <http://www.apcc.org.au/index.html>

191 See: <http://phi.uhce.ox.ac.uk/home.php>

In promoting a greater emphasis on public reporting, we are conscious of the need to tailor reports to the audience. For example, we heard and agree with the view that:

“Public reporting should be provided in a way that supports and develops community health literacy...Lessons from work done in Australia suggests that public reporting to consumers needs a meaningful narrative and should address issues of consumer concern and not just be a by-product of clinical or bureaucratic reporting.”¹⁹²

We should restate our position (articulated in our first report, *Beyond the Blame Game*) that we want public reporting to apply across all health services – public and private – and across all health settings.

Finally, we want to indicate our support for measures that encourage research and better understanding of people’s use of health services and health outcomes across different health settings and over time. To that end, we have recommended **linkage of hospital, medical and pharmaceutical data** using a patient’s Medicare card number. We also recognise and support the valuable work that is underway through the National Collaborative Research Infrastructure Strategy (NCRIS) to expand existing linked data collections nationally. This will mean that Australia will shortly have the world’s largest population-based health data linkage system¹⁹³. We believe that this represents a ‘burgeoning national resource’¹⁹⁴ to support research into improving health outcomes. Linkage of health data (with effective management and ethics protocols to ensure privacy and other safeguards) has generated important new knowledge in many areas including understanding patterns of cancer care, improving surgical outcomes, and reducing maternal and neonatal complications.

5.4 Well-designed funding and strategic purchasing models

The approach we take to funding or purchasing of health services is one of the critical underpinnings of the architecture of our future health system.

Our key message is that we must move to **a diverse toolbox of funding models**, so that we use the best approach to match each of our desired policy objectives. That is, we want a ‘fit for purpose’ approach to funding health services. To cite a well-known saying:

“If the only tool you have is a hammer, you tend to see every problem as a nail!”¹⁹⁵

We believe that we should carefully select the best ‘tool’ to fund health services, depending upon what we want to achieve in the circumstances. To illustrate this concept, our toolbox might include:

- activity-based funding to drive efficiency and improve access;
- episodic payments to drive continuity and a person-centred focus;
- outcome-based payments to reward improved performance on patient outcomes, quality and timeliness of care; and
- population or grant funding to support flexibility and population health needs.

Within this broad toolbox, we then need to ‘mix and match’, often using several different funding approaches to tackle particular dimensions of a policy challenge.

In the next two sections, we outline our recommendations on broadening our approach to funding health services. First, we discuss the Medicare Benefits Schedule. This is followed by a discussion on funding of hospitals, capital and some other issues.

¹⁹² M Draper (2008), Submission 265 to the National Health and Hospitals Reform Commission: First Round Submissions.

¹⁹³ The Sax Institute (2008), Submission 329 to the National Health and Hospitals Reform Commission: First Round Submissions.

¹⁹⁴ See the Centre for Health Record Linkage for examples of uses of linked data. At: <http://www.saxinstitute.org.au/researchassetsprograms/BetterHealthServicesThroughResearch/CHeReLPastEventsPresentationsDownloads.cfm?objid=772>

¹⁹⁵ A Maslow (undated), at: http://thinkexist.com/quotes/abraham_maslow/

5.4.1 Moving beyond fee-for-service in funding medical and other health services

We discussed in Section 4.3 how our recommendations would result in the evolution of a fundamentally different Medicare.

The current Medicare Benefits Schedule is largely about paying benefits on a fee-for-service basis for each visit to a doctor. In the future, we believe that Medicare will cover a broad array of health services. This will flow from our recommendations that the Commonwealth Government assume policy and funding responsibility for existing state-funded primary health care services and public hospital outpatient services (see Chapter 6). It will also be a consequence of recent Budget decisions to extend the Medicare Benefits Schedule to other health professionals, such as midwives and nurse practitioners. In addition, our recommendations to strengthen primary health care through the establishment of Comprehensive Primary Health Care Centres and Services, together with encouraging voluntary enrolment of some patient groups with a primary health care service, have major implications for how the Commonwealth Government funds primary health care in the future.

We believe that fee-for-service will continue as the backbone of paying for many medical services under Medicare. However, other funding approaches will also be required to meet the challenges of an evolving Medicare described above. Moreover, we want to create strong incentives for collaborative, multidisciplinary team-based approaches to providing health services. Fee-for-service is not necessarily the right 'tool' to achieve this goal, as implied below:

“ As economists have often pointed out, we pay doctors for quantity, not quality. As they point out less often, we also pay them as individuals, rather than as members of a team working together for their patients. Both practices have made for serious problems.

*Providing health care is like building a house. The task requires experts, expensive equipment and materials, and a huge amount of coordination. Imagine that, instead of paying a contractor to pull a team together and keep them on track, you paid an electrician for every outlet he recommends, a plumber for every faucet, and a carpenter for every cabinet. Would you be surprised if you got a house with a thousand outlets, faucets, and cabinets, at three times the cost you expected, and the whole thing fell apart a couple of years later?*¹⁹⁶

This is not to suggest that fee-for-service is not a satisfactory approach to paying for single visits to the doctor. But it is far from ideal as the only funding tool in responding to how we want Medicare to evolve in the future.

Encouraging collaborative, multidisciplinary teams and supporting voluntary enrolment will require the use of blended funding models. We are recommending that, in the future, primary health care services would receive funding that comprises:

- **Ongoing fee-for-service payments** – this will continue to make up most of the funding of a primary health care service, supporting the medical care provided to both enrolled and non-enrolled patients;

196 A Gawande (2009), 'The cost conundrum', The New Yorker, 1 June 2009, at http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande

- **Grant payments** – these will support multidisciplinary clinical services and care coordination. The size of the grant would be linked to the volume of patients enrolled with the primary health care service. This funding could be used to engage nurses and other health professions to provide a broader range of services. To support better coordinated and integrated care, this funding could also be used to acquire infrastructure such as clinical information and practice management systems and to fund non-clinical support staff to assist in managing the service;
- **Outcomes payments** – these payments would seek to reward good performance in outcomes for enrolled patients. This area is a work in progress and would need to be developed with strong clinical input to ensure that new payments did not create perverse incentives. This could evolve to reward improvements in patient outcomes and/or improvements in the integration of evidence into clinical practice. We recognise that many factors other than payment arrangements are important in influencing the quality and outcomes of health care delivery; and
- **Episodic or bundled payments** – these payments would be developed over the longer term. They would bundle together the cost of packages of primary health care for enrolled individuals over a course of care or period of time, substituting for fee-for-service payments. For example, they would allow the primary health care service to provide complete primary health needs including medical management, nurse practitioner care, allied health and mental health services. (This could include psychological support, exercise and diet/weight management, and self management and self care programs). The development of episodic payments will not happen overnight, nor would they be applicable to all patients. But the use of episodic payments would create greater freedom for primary health care services to take a long-term, whole person and population health perspective that moves away from funding on the basis of single consultations or visits.

In conclusion, we want a diversity of funding approaches to supporting primary health care services under Medicare. Of particular importance is the need to move towards greater use of ‘person-centred’ payments – that relate to a course of care or period of time – so that we can better meet the needs of people with chronic and complex conditions.

5.4.2 Driving efficiency and outcomes-based purchasing of health services

We also need to reform how we fund hospital services.

In June 2009, we released a background paper that reviewed the literature on the potential for efficiency gains in the Australian health system.¹⁹⁷ One of the significant findings in this paper was that **the hospital sector offers major potential for the achievement of efficiency gains**. We understand that many hospital staff will dispute this finding and argue that we actually need to spend more, not less, on hospitals if we are to respond effectively to existing problems with the quality and timeliness of hospital care. We want to argue that these two concepts – wise investment and improved efficiency – are not mutually incompatible and should occur in tandem.

First, we need to explain briefly what the findings on hospital efficiency mean. Multiple studies indicate that the cost of providing care in Australian hospitals can vary significantly between hospitals. These findings hold true whether we look at public hospitals or private hospitals (there are potential efficiency gains to be realised in both sectors).¹⁹⁸ Differences in the efficient costs of delivering hospital services also exist within individual states, as well as between different states and territories.

¹⁹⁷ National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, at: www.nhhrc.org.au

¹⁹⁸ The question of the relative efficiency of public and private hospitals is currently under review by the Productivity Commission. See: <http://www.pc.gov.au/projects/study/hospitals>

Based on reviewing multiple Australian studies, the Productivity Commission concluded that the 'productivity gap' between existing and optimal efficiency for Australian hospitals might be, on average, in the order of 20-25 per cent.¹⁹⁹ But this does not mean that savings of this order of magnitude can realistically be achieved. Some of the observed differences in the cost structures across different hospitals may reflect legitimate policy choices, such as deciding to provide services to small rural and remote communities (at inevitably higher costs due to the lack of economies of scale, higher transport costs and other reasons). Other factors contributing to differences in cost structures may not be amenable to action by individual hospitals, but may require national reforms. (A good example of this is the potential savings that could flow from greater uptake of information technology – such as computerised physician order entry systems, electronic health records and decision aids – in the health sector).

To improve the efficiency of hospitals, we are recommending **the use of 'activity-based funding' for both public and private hospitals** using casemix classifications. Activity-based funding is the new term being used by governments²⁰⁰ to refer to making payments on the basis of 'outputs' delivered by health service providers. In the case of hospitals, the output can be a hospital admission, an emergency department visit or an outpatient consultation. Typically, casemix classifications have been developed for admitted patient services – these bundle together the full range of services received by a patient during an admission to hospital (including accommodation, operating theatre, pathology, radiology, nursing and allied health services, pharmaceutical and medical services). Activity-based funding explicitly links funding to the actual services provided. It allows funders to compare the costs across different health service providers (such as hospitals) in providing the same health service (such as a hip operation).

How do our recommendations on activity-based funding relate to what has already been agreed?

In March 2008, the Council of Australian Governments agreed:

“... for jurisdictions, as appropriate, to move to a more nationally consistent approach to activity-based funding for services provided in public hospitals – but one which also reflects the Community Service Obligations required for the maintenance of small and regional hospital services.”²⁰¹

In December 2008, all governments signed up to the new National Health care Agreement, which includes an implementation plan for moving towards activity-based funding for public hospital services.

We need to be clear that our recommendations on activity-based funding go considerably beyond what has already been agreed by governments and would compel action at a faster pace. In essence, the Commonwealth and state and territory governments have agreed to develop 'classification' and 'costing' models for the next five years until 2013-2014. States and territories are still being funded under the new National Health care Agreement on a per capita or population basis – they are not being funded on a true activity-based funding approach related to how many health services they deliver.

We want governments to move beyond this 'Potemkin village' approach of classification and costing models and actually implement activity-based funding by the Commonwealth Government of public hospital services. This would represent a seismic shift in federal financial relations in the health domain. It would shift the Commonwealth Government from its existing passive funding role of providing block grants to the states and territories. It would mean that the Commonwealth Government is directly exposed to the cost and volume pressures of public hospital services. We will describe further in Chapter 6 how we believe that activity-based funding should be used to transform governance arrangements. For now, we want to emphasise that moving to the use of activity-based funding must be a major plank in driving greater efficiency in hospital services.

199 Productivity Commission (2006), Potential benefits of the national reform agenda: Report to the Council of Australian Governments (Commonwealth of Australia: Canberra).

200 See the National Partnership Agreement on Hospital and Health Workforce Reform, at: http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_hospital_and_health_workforce_reform.rtf

201 Council of Australian Governments (2008), Communique 26 March 2008, at: http://www.coag.gov.au/coag_meeting_outcomes/2008-03-26/docs/communique20080326.pdf

Our recommended reforms on activity-based funding sit within the following package of complementary reforms:

- **Activity-based funding approaches will need to be developed for other services** (over and above acute hospital admissions) including **sub-acute services and ambulatory services** provided by public hospitals. They also need to cover the full range of health care activities, including clinical education;
- Not all hospital services are amenable to funding on the basis of outputs. For example, we are recommending that **emergency departments be funded through a combination of fixed grants** (to fund availability) **and activity-based funding**; and
- **Activity-based payments need to include the cost of capital** (related to maintenance, repair and replacement of existing equipment and infrastructure). However, we are separately recommending that **governments invest in new 'transformational' capital** to achieve the major redesign of our health system described in Chapter 4. This includes investing in the establishment of Comprehensive Primary Health Care Centres and Services, expanding sub-acute services, reshaping the roles and functions of public hospitals, and expanding clinical education across all health service settings.

We need to balance the use of funding that drives efficiency with funding approaches that, over time, move health services to a greater focus on health outcomes, as suggested below:

“ Perhaps the greatest hope for improving both allocative and productive efficiency will come from efforts to measure and reward accurately outcome productivity – improving health outcomes using cost-effective management of diseases – rather than rewarding on the basis of unit service productivity for profitable stents, caesarean sections, and diagnostic imaging regardless of their impact on health outcomes. Such a change in emphasis will require rethinking what we pay physicians and hospitals for and, most importantly, how to measure and pay for outcomes rather than inputs.²⁰²

A **move to funding on the basis of outcomes** should be the long-term objective. We earlier identified the need to expand the use of outcome payments in funding health services under an evolving Medicare. This should apply equally to all health care, including hospital services.

5.5 Knowledge-led continuous improvement, innovation and research

We believe that our future health system should be driven by a strong focus on continuous learning and being able to readily apply new best knowledge to improve the delivery and organisation of health services. Innovation should be rewarded and recognised, at local and national levels, with clear strategies to share and embed successful local innovations across the whole health system. A vibrant culture of innovation and research should permeate health services, with effective linkages and partnerships across universities, research institutes, and hospitals and health services. Evidence should drive investment and disinvestment in particular health care services, as well as influencing the allocation of resources and the deployment of our health workforce.

Our reforms seek to embed innovation, learning and research through actions targeted at both the national level and at the local level of individual health services.

202 A Garber and J Skinner (2008), 'Is American health care uniquely inefficient?' *Journal of Economics perspectives*, 22(4): 27-50.

5.5.1 Providing national leadership on evidence and knowledge management for our health system

There are many groups that play a key role in helping drive an evidence-based approach to health service delivery. Our major public teaching hospitals and health services, universities, major research institutes, the NHMRC, the CSIRO, professional colleges and special disease interest organisations all contribute to the 'knowledge repository' that helps influence and continuously improve health care. The efforts of the committed people working in such bodies are often poorly acknowledged and often without financial reward; they are to be commended.

Our recommendations have focused on supporting and complementing the work of these groups through strengthening some important national functions as follows:

- **Establishing a permanent national safety and quality organisation:** We want the Australian Commission on Safety and Quality in Health Care to shift from being a 'temporary' body to being established as a permanent, independent national organisation. It has a big job ahead of it. We have earlier (see Section 5.3.3) outlined how we want this agency to take the lead in **analysing and reporting on safety and quality** and in overseeing national patient experience surveys and the collection of patient reported outcome measures. We also want it to take on the leadership role in promoting a culture of safety and quality across our whole health system. Facilitating **clinical improvement collaboratives** and **recognising high achievers** are just two examples of national leadership which will help engender a bottom-up culture and enthusiasm for continuing quality improvement. We envisage that this agency could take responsibility for disseminating and promoting innovation, evidence and quality improvement tools. It also needs to identify research priorities, be an advocate, and monitor the regulatory framework for safety and quality;
- **Dissemination of innovation and evidence:** Getting evidence to health professionals at the coalface is also critical if we are to effect real improvements in health outcomes for people. We have recommended strengthening the role of the National Institute of Clinical Studies in disseminating knowledge and evidence about how we can best organise and deliver safe and high quality health care. We need to take the 'legwork' out of the process if we wish clinicians to keep up-to-date with the latest evidence and then support them to apply it in their everyday clinical practice. A dynamic **national 'clearinghouse' of current health knowledge** including evidence-based guidelines, protocols and 'risk alerts', potentially accessible via an electronic portal, can assist to promote a culture of excellence and continuous improvement across the health system;
- **National direction on research priorities:** We have recommended that the National Health and Medical Research Council set clear priorities for collaborative research centres and supportive grants. The 'hub and spoke' model used by the NHMRC Centres for Clinical Research Excellence offers real potential for a collaborative, multidisciplinary approach across health settings;
- **National investment in research:** We have recommended greater investment in public health, health policy and health services research including ongoing evaluation of health reforms. Research grants must incorporate the indirect infrastructure costs as well as the direct costs irrespective of the setting in which such grants are taken up (including within health services, universities or research institutes). In addition, research funds need to be allocated in a more flexible way to encourage uptake by, and collaboration between, practising clinicians, health service managers and policymakers via fellowships and exchanges; and
- **National evaluation and assessment of health interventions:** We have already briefly mentioned in discussing prevention and health promotion that we are recommending a new 'umbrella' approach to the assessment of health interventions. This involves bringing together the existing and separate approaches to evaluating new medical services (through the Medicare Services Advisory Committee), new pharmaceuticals (through the Pharmaceutical Benefits Advisory Committee) and other processes for reviewing technology and devices to form the platform of a nationally consistent approach to the evaluation of all health services. The potential of many emerging technologies highlighted in Chapter 1 will require a more rigorous cost-effectiveness evaluation framework if we are to ensure a value-driven approach to the uptake of new technologies.

5.5.2 Driving innovation and learning at the local level

Our health workforce also has to be empowered to take on the challenge of continuous learning, research and innovation. We must create structures and models that encourage **knowledge transfer and the translation of evidence to everyday practice** in an effective and pragmatic manner (such as clinical decision support).

We also need to train, develop and empower clinical and health service leaders to mould a culture of continuous reflection and self-improvement which will inspire the generations of health professionals to come. Promoting a culture of mutual respect and patient focus through shared values and educational experiences, collegiality between leaders of clinical and corporate governance, and appropriate recognition and compensation arrangements is intrinsic to job satisfaction and retention of our precious health workforce.

We have already described the value in ensuring that clinicians working in our health services have access to 'smart data' on the clinical quality and outcomes of their own practice, as well as the performance of their local health service. But they also need to have the time and the skills to interpret and compare performance data over time with other 'like' facilities if they are to identify and take positive action to change clinical practice. Access to quality improvement tools, techniques and networked systems of support are essential to helping clinicians lead changes in practice or apply new models of care. To make best use of performance data and quality improvement methodologies, all health professionals would undoubtedly benefit from the inclusion of **standard national safety and quality training modules** into accredited education and training programs.

Strong health leadership is vital to making change actually happen. It is unrealistic to think that our health workforce can take on leadership roles without action to train and develop those with potential. **There must be investment in management and leadership skills development** for existing and future managers and clinician leaders at all levels and across all sectors.

Valuing clinical leadership and embedding a culture which frees health professionals to invest time in quality improvement may be as important as structural change in achieving health reform. We heard:

“ Those systems that appear to have achieved the highest levels of quality and efficiency relied less on structure than on cultural change at all levels, supported by tools and techniques such as advanced access scheduling, queuing theory, etc ²⁰³

Providing health professionals with opportunities to combine teaching and research with their service responsibilities builds a culture of quality and is demonstrated to lead to better uptake of new knowledge and better outcomes. Concerns have been voiced in a number of quarters that:

“ The key associated functions of education of future health professionals or of research, so critical to the quality and development of services over the years, have been seriously downplayed.... These aspects of the functions of hospitals were always the basis of professional pride in hospital performance which led to great efforts on the part of doctors, nurses and others to go beyond the call of duty to solve problems and deliver the best possible outcomes for patients.²⁰⁴

203 Menzies Centre for Health Policy (2009), Submission 199 to the National Health and Hospitals Reform Commission: Second Round Submissions.
204 D Pennington (2009), Submission 164 to the National Health and Hospitals Reform Commission: Second Round Submissions.

Clinical education and training must be 'protected' from the daily demands of health service delivery if we are to foster a culture of clinical engagement in health service management. Hence we have recommended that **clinical education and training be funded through the use of dedicated 'activity-based' payments**, so that these important functions are appropriately rewarded. Against this backdrop, we recognise the need to **adequately invest in a broad array of research including health services research, public health and health policy research**. We also want to see **clinical research fellowships** established across hospitals, aged care and primary health care settings so that research is visible and regarded as a normal part of providing health services.

Recognising and rewarding excellence in patient care and outcomes, innovation and research achievements and outstanding performance can build a cohesion and culture of pride in health services. Examples such as 'magnet hospitals'²⁰⁵ and a range of prestigious research awards have demonstrated sustained and strengthened quality improvement in health services that aspire to and achieve such recognition. We have therefore recommended **a national health care quality innovations awards program** be established, which would apply to excellence achieved across all health service settings.

There are many good examples of existing programs that seek to encourage innovation and learning at the level of individual health services. We have already mentioned the Australian Primary Care Collaboratives Program. Similarly, many hospitals across Australia have participated in benchmarking groups and clinical forums that focus on 'redesign' and improving care. We want to encourage **greater participation in forums such as breakthrough collaboratives and health roundtables** that contribute to the sharing of 'best practice' lessons across health services. Sharing innovation is an essential prerequisite of a self-improving health system that is able to respond to a dynamic and changing environment.

205 F Armstrong (2005), 'Magnet hospitals: What's the attraction?', *Australian Nursing Journal* 12(8): 14-17.

CHAPTER 6

REFORMING GOVERNANCE



6. Reforming governance

6.1 Introduction

“Governance is important. It is not a separate issue from practical measures aimed to improve service delivery and health outcomes. It is the means by which the Australian community can be sure that the health system is delivering what it is there for. Moreover, current governance arrangements are contributing directly to current weaknesses in the quality, effectiveness and efficiency of the Australian health system.”²⁰⁶

In the strictest terms, governance refers to the structures and processes used to regulate, direct and control the health system.²⁰⁷ However, when people speak about governance, they tend to see it as something broader, something reflecting the values and history of the health system as well as its future.

We believe that governance is primarily about leadership and stewardship of the health system. Good leadership will set a clear vision and put in place the policy, regulation, financial management, programs and structures to ensure the best possible health of – and health care to – Australians. Good stewardship will make sure our health system is capable of delivering the best possible health care to future generations.

To ensure Australia’s health system is sustainable, safe, fair and agile enough to respond to people’s changing health needs and a changing world, we need to make significant changes to the way it is governed. We recognise that these high-level structural changes will not, and cannot, rectify all the problems with our health system. That is why we have made many recommendations in this report for changes to specific areas of health care. We believe, however, that some of the problems with the health system will only improve by reforming governance arrangements.

6.2 Problems with existing governance arrangements

In Australia, responsibility for health care is divided between two levels of government. They have different approaches to funding, different relationships with health service providers, and different responsibilities for various parts of health care. The two levels of government also have different capacities to meet the costs of services from their own revenue.

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. State funding is largely allocated to public hospitals and some community based care. The Commonwealth Government provides funding support to the states for free public hospital care, reimburses people for most of the cost of pharmaceuticals, general practice and specialist medical care, and subsidises aged care and private health insurance.

There are advantages in our federal system with two levels of government sharing responsibility for health funding: they share the financial costs and risks of ill health, and reforms are often more highly scrutinised when cooperation between governments is required;²⁰⁸ health services managed at the sub-national level are often more responsive to local need; and there is scope for greater diversity in developing and implementing innovative solutions to unique circumstances and policy problems. States are also better equipped to take an ‘intersectoral’ approach to health care because they are primarily responsible for many other areas of public policy – education, police, housing and transport, for example – that have a major impact on health outcomes.

206 A Podger (2009), Submission 294 to the National Health and Hospitals Reform Commission Interim Report. Second round submissions.

207 J Dwyer and K Eagar (2008), ‘Options for reform of Commonwealth and State governance responsibilities for the Australian health system’, Discussion paper commissioned by the National Health and Hospitals Reform Commission, p 1.

208 A Twomey and G Withers (2007), ‘Federalist Paper I: Australia’s Federal Future’, report to the Council for the Australian Federation.

However, the evidence is strong that federal systems work best when the different levels of government have clearly delineated roles and responsibilities and adequate funding to meet them. These are the basic conditions for good governance. As far as possible, governments should be directly responsible and accountable for the effects funding decisions have on programs. Conversely, the fiscal implications of policies and program management decisions should rest with the government making the decisions. This is not the case for health services in Australia at the moment.

In health care, 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.

The states are dependent on Commonwealth Government funding to meet their responsibilities for health services, but there is no clear, agreed basis for determining the level of (or in the states' view, ensuring the adequacy of) the Commonwealth Government's support. States try to maximise the available Commonwealth Government funding through 'cost shifting' – shifting the cost of patient care to services that are the funding responsibility of the Commonwealth Government. 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'.

For consumers and health professionals, it is fair to say that there is widespread dissatisfaction with the consequences of the split in funding responsibilities – the fragmentation of services, perverse financial incentives that lead to the underfunding of key parts of the health care continuum, the duplication and administrative waste, and difficulties navigating a complex system.

Health professionals working in a demand pressured system are looking for leadership and a voice. They want better decision making, both at the national and local level.

Furthermore, there is a lack of transparency and no clear leadership across the whole system. People do not find it easy to know which government to hold to account – or how to effectively hold them to account – for their access to health care and the quality of that care, and resent it when governments focus on shifting cost and blame rather than making things work.

From our consultations around Australia, it is clear that the public and the people working at the frontline of health are tired of the blame game. They want reforms put in place that will make our health system work well, but many are concerned about the ability of our governments to work effectively together to do so.

6.3 Our recommendations

In our Interim Report, we discussed a number of proposals for reforming the governance arrangements for Australia's health system. We received many submissions and held consultations and special seminars on these reform proposals.

On the basis of our deliberations and consultations, we are now putting forward two main recommendations, which we agree should be pursued concurrently.

The first recommendation calls on First Ministers to agree to a new Healthy Australia Accord that clearly articulates the agreed and complementary roles and responsibilities of all governments in improving health services and outcomes for all Australians. The Accord retains a governance model of shared responsibility for health care between the Commonwealth and state governments, but with significantly re-aligned roles and responsibilities. The new arrangements provide for:

- clearer accountabilities;
- better integrated primary health care, dental care and aged care, under Commonwealth Government funding and direction; and
- improved incentives for more efficient use of hospitals and specialist community based care, through changed funding arrangements.

The Healthy Australia Accord would also shift the system towards 'one health system', identifying functions to be undertaken on a consistent national basis to improve quality, efficiency, fairness and sustainability.

While we agree that there will be significant benefits from these governance reforms – and their implementation should commence now – we also believe there is a real need to further improve the responsiveness and efficiency of the health system and its capacity for innovation. We agree that greater consumer choice and provider competition, and better use of public and private health resources, have the potential to achieve this, and propose developing a new governance model for health care that builds on and expands Medicare.

The new model we are proposing is based on the establishment of 'health and hospital plans'. It draws upon features of social health insurance and encompasses ideas of consumer choice, provider competition and strategic purchasing. We have given this new governance model the working title, 'Medicare Select'.

There are, however, many technical and policy challenges in developing and implementing such an approach, and a number of design choices about how health and hospital plans might work that we have not been able to fully address. We therefore recommend that, over the next two years, the Commonwealth Government commits to exploring the design, benefits, risks, and feasibility around the potential implementation of 'Medicare Select'. Our two main recommendations are discussed further below.

6.4 Healthy Australia Accord

A new Healthy Australia Accord would reflect the agreement of the Commonwealth and state and territory governments to work cooperatively to achieve improved health outcomes and health services for all Australians. While the Accord could encompass many of our proposed reforms, here we highlight three structural reforms to governance of the health system:

- shifting Australia's health system towards 'one health system', particularly by defining a range of functions to be led and governed at the national level, to ensure a consistent approach to major governance issues;
- realigning the roles and responsibilities of the Commonwealth and state and territory governments, increasing the responsibilities of the Commonwealth Government with the aim of driving better integrated primary health care, dental care and aged care; and
- changing the funding arrangements for public hospitals and public health care services, with the Commonwealth Government paying the state and territory governments activity-based benefits using casemix classifications for public hospital care and other public health care services, thereby sharing the financial risk associated with growth in demand and providing strong incentives for efficient care.

6.4.1 Moving towards 'one health system'

In our Interim Report, we reflected back the strong message we heard from many consumers and health professionals – a desire for 'one health system'. While the Commonwealth, state and territory governments all have important roles in health care, we agree that there needs to be a national approach for some key governance functions. A national approach does not necessarily translate to direct control by the Commonwealth Government. It will often involve collaboration between the Commonwealth Government, states, as well as other agencies.

In our Interim Report, we proposed – and now we recommend – that a range of functions be led and governed at the national level, including:

- leadership for patient safety and quality;
- health promotion and prevention;
- professional registration;
- workforce planning and education;

- performance monitoring and reporting;
- private hospital regulation;
- e-health;
- technology assessment; and
- research and innovation.

In each of these areas, we believe that a consistent national approach will improve the capacity of Australia's health system to deliver high quality services. For example, one of the biggest challenges we face for the future of our health system is ensuring we have enough skilled health professionals. A national approach to workforce planning and education will help ensure we have the right health professionals in adequate numbers across Australia.

To take another example, our recommendation to introduce a national approach to performance monitoring of health services will improve accountability for patient outcomes right across Australia. Performance monitoring should occur at the institutional level (for example, hospitals and health centres) and at the provider level, using a comprehensive range of performance indicators. Where appropriate, minimum performance benchmarks should be set. Comparative data should also be made available to ensure transparency and accountability.

6.4.2 Better integrated care through strengthened Commonwealth Government responsibilities

The second major governance reform under the Healthy Australia Accord responds to the problems for patient care caused by splitting responsibilities between the Commonwealth Government and state governments. As discussed above, this split results in fragmented, poorly integrated care, and a lack of accountability for patient outcomes. To address this, under the Healthy Australia Accord we are recommending that the Commonwealth Government take over full responsibility for the policy and public funding of primary health care, basic dental care, and aged care. Furthermore, we are recommending the Commonwealth Government be responsible for purchasing health services for Aboriginal and Torres Strait Islander people.

The Australian health system, like most others, focuses disproportionately on curative health services delivered mainly in hospitals. In our Interim Report, we argued strongly that there was a need to improve the focus on primary health care. Primary health care is the foundation of our health system, but it needs clearer direction and better integration into the system as a whole. The current split in funding and responsibility between the Commonwealth and state governments weakens the effectiveness of primary health care, distorts priorities, and causes problems in service delivery.

After consultations on our Interim Report, our view has only strengthened on these issues. Our recommendations for a transformed and comprehensive primary health care platform (see Section 4.2.1) require one government – the Commonwealth Government – to be responsible and accountable for the strategic direction, planning and public funding of primary health care. Thus, we recommend that 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. This change must complement and strengthen Australia's ongoing population health and public health strategies, which would continue to be jointly funded by the Commonwealth and state and territory governments.

Second, we recommend that the Commonwealth Government assumes full responsibility for providing universal access to basic dental care (preventive, restorative and dentures).

Under the existing arrangements, the Commonwealth Government and states and territories are responsible for funding numerous different programs to support dental care, and yet many people are unable to access the care they need. Our proposed 'Denticare Australia' scheme (see Section 3.2.1) would enable everyone to choose either to rely on improved provision of public dental services, or to enrol with a publicly-funded private dental insurance plan.

Third, we recommend that the Commonwealth Government assume sole responsibility for public funding of aged care services.

While the Commonwealth Government is currently responsible for most funding of aged care services, there are some areas of shared responsibility. Home and Community Care (HACC) services are partly funded by the states, and both HACC and Aged Care Assessments are provided by state and territory governments. Transferring responsibility for HACC for older people and aged care assessment to the Commonwealth Government will enable it to develop more consistent, streamlined assessment processes, and provide more integrated care to meet people's needs. These changes are discussed in more detail in Chapter 4.2.3.

And fourth, we recommend that the Commonwealth Government assume full responsibility for the purchasing of all health services for Aboriginal and Torres Strait Islander people through the establishment of a National Aboriginal and Torres Strait Islander Health Authority (see Section 3.2.4).

With the transfer of full funding responsibility to the Commonwealth Government for aged care, basic dental care and – in particular – primary health care, there will be a reduction in the vertical fiscal imbalance between the Commonwealth Government and the states. The assumption of greater funding responsibility by the Commonwealth Government would be met through commensurate reductions in grants to state, territory and local governments and/or through changes to funding arrangements between governments.

6.4.3 More efficient funding of public hospitals and health care services

The third significant change to governance arrangements under the Healthy Australia Accord involves reforming the funding arrangements for public hospitals and health care services. The Commonwealth Government would be responsible for paying the state and territory governments an activity-based benefit using casemix classifications. Similar to the changes to primary health care, dental and aged care discussed above, the Commonwealth Government's increased funding responsibilities for public hospitals and public health care services would also be met through a proportionate adjustment to state grants.

Under the new funding arrangements we are recommending, the Commonwealth Government would:

- 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, sub-acute or mental health care facility and every attendance at a public hospital emergency department. This approach provides the opportunity for the Commonwealth Government's share to be incrementally increased over time, allowing for it to fund up to 100 per cent of the costs of these public hospitals and public health care services in the future (this is discussed further below);²⁰⁹ 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 Commonwealth Government must include in the efficient price the relevant proportion (40 per cent or 100 per cent) of the cost of capital.

It is assumed that the states would mirror these purchasing arrangements, using efficient activity pricing, in funding public hospitals and health services.

Further details on the funding arrangements are outlined in Table 6.1.

²⁰⁹ There are existing arrangements covering the treatment of private patients in public hospitals, which are related to Commonwealth government regulatory and financial support for private health insurance. Our recommendations on activity-based funding do not address this issue.

Table 6.1: Payments by the Commonwealth Government for public health care services

Admitted patients will be funded using the Australian Refined Diagnosis Related Groups (AR-DRGs). Sub-acute patients will be funded using either the Casemix Rehabilitation and Funding Tree (CRAFT), the Sub-acute, Non-acute and Palliative Care classification (SNAP) or other agreed system.

Hospital emergency services will be funded using a combination of grants and activity-based funding. Grants will be necessary in both areas of low demand – where services are still required – and of high demand – where spare bed capacity needs to be funded to ensure the emergency department can admit patients in a timely manner.

The Commonwealth Government would also be responsible for paying 100 per cent of the efficient cost of care for **hospital outpatient attendances** up to an agreed activity level per year per state or territory. The Victorian Ambulatory Classification System is likely the best available classification to be used to fund non-admitted public hospital services in the immediate future.

There would be a number of benefits from these changed funding arrangements. The most significant would be that the Commonwealth and state governments would share the financial risk associated with growth in demand for public admitted patient services. This will provide incentives for cooperative action that ensures hospitals are only used when they are the best and most efficient form of care. For example, the Commonwealth Government will be able to invest in effective primary health care and, together, governments will be encouraged to develop alternative, more appropriate services, such as hospital-in-the-home, step down and sub-acute care, and post-acute care.

Through activity-based funding, the Commonwealth Government will also be exposed to the risk of increased demand for emergency and outpatient department attendances. Faced with this risk, the Commonwealth Government will have a vested interest in considering whether possible alternatives – in particular, primary health care and specialist care – are being effectively used where they are the most appropriate form of care.

The shift to casemix based funding for all hospitals will also have significant efficiency gains. 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 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.

Our preliminary estimates suggest 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 to up to about \$1.3 billion every year (see Appendix H for details).

The shift to activity-based funding will also provide strong incentives for public health care services to innovate and deliver high-quality care at the most efficient cost. For example, under the new governance arrangements, the Commonwealth Government's share of hospital funding will be limited to a set proportion (40 per cent) of the efficient cost of each episode of care. The price paid for this care, therefore, may be different from the actual cost of delivering care. The state governments will be responsible for funding the remainder of the cost. If the states are continually underwriting inefficient hospital performance, they will have an increased incentive to work with hospital management and clinicians to improve the efficiency of service delivery while maintaining the quality of care.

These changes to funding arrangements will also help to lessen disputes about the adequacy of the Commonwealth Government's funding contribution, and reduce the 'blame game'. While debates about the 'efficient cost of care' are inevitable, the availability of comparable data on the cost of delivering hospital services will make these debates more transparent and amenable to resolution.

Finally, the adoption of open-ended activity-based funding by the Commonwealth Government for a share of the cost of public health care services will effectively relieve states of 40 per cent of the cost of providing these services. If there were any increases in volume or in the efficient costs of delivery, states would only have to find their share. This will significantly reduce the effects of vertical fiscal imbalance in the health sector.

Moving towards a single government funder

As discussed above, we recommend that the Commonwealth Government fund 40 per cent of the efficient cost of care for every admitted episode of acute care and sub-acute care for public patients, and for every attendance at a public hospital emergency department. As the Commonwealth Government builds capacity and experience in purchasing these 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 effect, in combination with the recommended full funding by the Commonwealth Government of primary health care, aged care and outpatient services, the 100 per cent funding of admitted public hospital and health care services and emergency attendances would mean that there was close to a single government funder of health services in Australia. While the states would continue to be responsible for funding some activities and services (for example, the gap between the 100 per cent of the efficient cost of care and the actual cost of delivering care, state public and population health responsibilities, and health related research), 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.

Moving to a single government funding system for health services would transform the way health services operate in Australia. Importantly, it would drive efficiency and help contain the budgetary cost of health care. As pointed out above, the Commonwealth Government would fund public health care services across Australia at the efficient price for delivering those services. Furthermore, under this system, the Commonwealth Government would have powerful incentives as well as the capacity to influence and re-organise services so that the balance was as effective and efficient as possible. The shift to a single national public funder, therefore, could substantially improve both allocative and operational (technical) efficiency in the Australian health system.

The shift to a single government funding system would also ensure that the Commonwealth Government would develop a detailed and comprehensive understanding of health care delivery across all services. Over time, it would also develop national data and systems for funding and remunerating all health care services. This information would help the Commonwealth Government transition from a funder of services to a purchaser of services if the 'Medicare Select' model was adopted in the future. For example, future innovations in purchasing episodes of care as bundled payments for services across primary health care, acute and community based services could influence health service organisations and encourage them to form more integrated health service networks.

Under this option of 100 per cent funding of public health services, the Commonwealth Government would have the option of making payments directly to public hospitals and public health care services for the activity, instead of to the state governments. In effect, the Commonwealth Government would pay a hospital or health care benefit to a public hospital or public health care service according to the care that the health service provides to a person, based on the efficient cost of providing that episode of care.

While we recognise the potential benefits of moving to a single government funder, we also acknowledge some further possible implications.

In particular, the changes could influence the provision of public hospital services. While under this proposal there would be no direct change to the provider arrangements – that is, the states and territory governments would remain responsible for operating public hospitals – with its increased financial exposure, the Commonwealth Government would be expected to increase its policy and planning control of public hospitals. The Commonwealth Government would also reduce GST revenue to the states to reflect its increased funding of public health care services, constraining the financial flexibility of the states.

With their reduced financial flexibility and responsibility, it is possible that the states would move to reduce their management responsibility for public hospitals, and hence accountability for performance that they would view as increasingly outside of their control. The states might, for example, decide to corporatise their hospitals as government owned enterprises and/or transfer the staff and assets to a form of public sector trust, with independent boards and management, similar to the arrangements in the United Kingdom.²¹⁰

6.4.4 Key benefits of the Healthy Australia Accord

The governance reforms proposed under the Healthy Australia Accord will transform relations between the Commonwealth Government and the states, and enable a much more coherent approach to policy, funding and service delivery.

The reforms encompass major changes to the allocation of responsibilities between governments and the management of continuing shared responsibilities. They will improve accountability, remove some of the boundaries and barriers to integrated care, and create common understandings and shared interests between governments that will facilitate cooperation and lead to improvements in the health system.

The changes we are recommending would expose the Commonwealth Government to an increased and more direct set of responsibilities covering all aspects of the health system. Even where the states remain involved – particularly in public hospitals and a range of publicly provided specialist services – the changes to funding arrangements will encourage shared responsibility for ensuring publicly provided services are accessible, efficient and effective.

The key benefits of the Healthy Australia Accord include:

- better integrated primary health care, dental care and aged care under Commonwealth Government funding and direction;
- greater incentives for investment in primary health care and sub-acute care;
- more efficient delivery of health care services, particularly from casemix funding of all public hospital services;
- improved accountability for performance through clarifying the responsibilities of the Commonwealth and state and territory governments; and
- a consistent, national approach in key areas of governance, such as safety and quality, workforce planning and education and e-health, where a national approach is important to ensure the delivery of high quality services across Australia.

The reforms proposed under the Healthy Australia Accord are achievable, as the Accord would build on the strengths of a federal health system – where all levels of government are involved in health care – while allowing the Commonwealth Government to take a greater leadership role. Our governance recommendations related to the Healthy Australia Accord are set out below.

210 National Health Service, A Short Guide to NHS Foundation Trusts, At: [http://www.dh.gov.uk/en/Health care/Secondarycare/NHSfoundationtrust/DH_072543](http://www.dh.gov.uk/en/Health%20care/Secondarycare/NHSfoundationtrust/DH_072543)

87. To give effect to a national health system, we recommend that First Ministers agree to **a new Healthy Australia Accord** that will clearly articulate the agreed and complementary roles and responsibilities of all governments in improving health services and outcomes for the Australian population.
88. The Healthy Australia Accord would incorporate the following **substantial structural reforms to the governance of the health system**:
- 88.1 The Commonwealth Government would assume full responsibility for the policy and public funding of **primary health care services**. This includes all existing community health, public dental services, family and child health services, and alcohol and drug treatment services that are currently funded by state, territory and local governments.
- 88.2 The Commonwealth and state and territory governments would move to new transparent and more equitable funding arrangements for **public hospitals and public health care services** as follows:
- The Commonwealth Government would meet 100 per cent of the efficient costs of public hospital outpatient services using an agreed casemix classification and an agreed, capped activity-based budget.
 - The Commonwealth Government would pay 40 per cent of the efficient cost of care for every episode of acute care and sub-acute care for public patients admitted to a hospital or public health care facility for care, and for every attendance at a public hospital emergency department.
 - 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.
- 88.3 The Commonwealth Government would 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.
- 88.4 The Commonwealth Government would assume full responsibility for the purchasing of all health services for **Aboriginal and Torres Strait Islander people** through the establishment of a National Aboriginal and Torres Strait Islander Health Authority. This would include services that are provided through mainstream and community-controlled health services, including services that are currently funded by state, territory and local governments.
- 88.5 The Commonwealth Government would assume full responsibility for providing **universal access to dental care** (preventive, restorative and dentures). This would occur through the establishment of the 'Denticare Australia' scheme.
- 88.6 The Commonwealth Government would assume full responsibility for public funding of **aged care**. This would include the Home and Community Care Program for older people and aged care assessment.
- 88.7 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.
- 88.8 These changes to roles and responsibilities allow for **the continued involvement of states, territories and local governments in providing health services**.
- 88.9 The Commonwealth, state and territory governments would agree to establish **national approaches** to health workforce planning and education, professional registration, patient safety and quality (including service accreditation), e-health, performance reporting (including the provision of publicly available data on the performance of all aspects of the health system), prevention and health promotion, private hospital regulation and health intervention and technology assessment.

6.5 Embedding incentives for reform: beyond 'top down' reform

Similar to the current arrangements, the governance arrangements recommended under the Healthy Australia Accord share responsibility for health care between the Commonwealth and state governments, but with re-aligned roles and responsibilities.

Essentially, this model is a 'top down' approach to health care reform. It relies on governments reaching agreement on their responsibilities and jointly funding and delivering health care, albeit with improved accountability and performance management arrangements.

While these new governance arrangements would have significant benefits, we question whether the reforms would be sufficient to deal with the problems and issues raised in Chapter 1. This concern was shared by a number of submissions made in response to the Interim Report, as this statement illustrates:

“ The implementation of Option A and other recommendations in the Interim Report would deliver significant benefits. The question that arises is whether these would be sufficient to deal with the significant challenges facing our 'system' arising from an ageing population, community expectations, technological change and the other drivers which have been well documented elsewhere ²¹¹

In response to the governance options put forward in our Interim Report, many submissions supported the establishment of regional health authorities with responsibility to plan, commission and operate public health care services for their region, with the Commonwealth Government as the single government funder (Option B in the Interim Report). A number of submissions argued that this approach to governance would increase responsiveness to people's health needs, as the regional health authorities would be responsible for identifying local priorities for service development and health improvement, with the involvement of the health services and community.

We acknowledge that there are some positive features in Option B. After further considering the arguments, however, we do not support the establishment of regional health authorities because:

- 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.

However, we do agree that some elements of Option B – in particular, the move to a single national funder across the continuum of care, the development of strategic purchasing capabilities, and the focus on local innovation and service delivery – should be an integral part of governance arrangements for Australia's health system that move beyond the 'top down' reforms proposed under the Healthy Australia Accord. Further changes to governance arrangements must drive improved responsiveness, efficiency, and long term sustainability, while protecting fairness and equity.

211 H Owens (2009), Submission 250 to the National Health and Hospitals Reform Commission: Second round submissions.

Efficiency is about using health care resources to get the best value for money – about getting the right care at the right time, first time and over time. Sustainability is about ensuring we use our resources to meet the needs of the present population, without compromising the ability of future generations to meet their own needs. While a sustainable health system relies upon efficiency, it also requires self-improvement and innovation to meet the changing circumstances.

Regarding responsiveness, we are keen to highlight the importance of two forms:

- provider responsiveness to a person's needs in an episode of care – encouraged in particular by a consumer's ability to choose the provider; and
- responsiveness to a person's health needs over their lifetime – encouraged in particular by a health care organisation, such as a health and hospital plan, having responsibility for the whole of a person's care throughout life. This form of responsibility emphasises the importance of prevention and healthy behaviours, as well as integrated care and chronic disease management.

Overall, we are aiming for a system 'with incentives for reform embedded within it'.²¹² To embed incentives for responsiveness, efficiency and sustainability, we believe, requires greater consumer choice and provider competition.

6.5.1 Greater consumer choice and provider competition

There are three main arguments in favour of opening up the health system to greater consumer choice and provider competition:

- it empowers consumers through choice of provider – which can include both provider of a health care service and provider of a health care plan – promoting responsiveness to people's health needs and preferences;
- it creates the right incentives for health and hospital plans to attract and retain customers and deliver added value – to support their customers' health through innovative ways of commissioning services to get the best outcomes, consumer satisfaction and efficiency; and
- it provides the right incentives for health service providers to deliver both higher quality care and greater efficiency – providers face adverse consequences from not being chosen and will want to improve the quality and efficiency of services to attract users and funders.²¹³

While provider competition for users of a service takes place in a market, health care is better thought of as a 'quasi-market'. A quasi-market is like a market in the sense that there are independent providers competing for custom within it. But it differs from a normal market in at least one key way – users do not come to the quasi-market with their own resources to purchase services. Instead, services are paid for, at least in part, by government, but the money follows users' choices through a voucher, budget or funding formula. The quasi-market is thus a fundamentally egalitarian device, enabling public services to be delivered in ways that avoid most of the inequalities that arise in normal markets because people have different purchasing power.²¹⁴

In our Interim Report, we outlined a governance proposal based on consumer choice and provider competition under compulsory social health insurance (Option C in the Interim Report). We have received interesting and varied responses to this idea, ranging from concerns about the major implications of the scheme for current arrangements, to wholesale support for its introduction. Many commentators and leading health policy experts with varying views influenced and contributed to our thinking on this issue.²¹⁵

212 J Le Grand (2006), 'The Blair Legacy? Choice and Competition in Public Services', Transcript of Public Lecture, London School of Economics, at: <http://www.lse.ac.uk/collections/LSEPublicLecturesAndEvents/pdf/20060221-LeGrand.pdf>, p. 4.

213 J Le Grand (2007), *The Other Invisible Hand: Delivering Public Services through Choice and Competition*, (Princeton University Press, Oxford) p. 42.

214 J Le Grand (2007), *The Other Invisible Hand: Delivering Public Services through Choice and Competition*, (Princeton University Press, Oxford) p. 41.

215 While we note that they would not necessarily agree with our views, our development of 'Medicare Select' drew upon the work and advice of many people, including: H Owens (2009), Submission 250 to the National Health and Hospitals Reform Commission: Second Round Submissions; M Foley (2008), 'A Mixed Public-Private System for 2020', Discussion paper commissioned by the National Health and Hospitals Reform Commission; J Dwyer and K Eagar (2008), 'Options for reform of Commonwealth and State governance responsibilities for the Australian health system', Discussion paper commissioned by the National Health and Hospitals Reform Commission; R Scotton (2002), 'Managed Competition in Health Care: workshop proceedings', Productivity Commission, Canberra; A Podger (2006), 'A model health system for Australia', Inaugural lecture, Menzies Centre for Health Policy, Canberra; J Stoelwinder (2009), 'Sustaining Medicare – lessons from the Netherlands', public lecture at Menzies Centre for Health Policy, Canberra; J Butler and A Sidorenko (2007), 'Coping with the challenges of population ageing: Policy considerations for private sector involvement in a private health security pillar in a universal health system in APEC economies, Australian Centre for Economic Research on Health, Research Report No.2.

It is fair to say that, following feedback and further consideration, our views have evolved. In particular, rather than importing an 'outside' social health insurance scheme to Australia – which could be implied by Option C – we have focused on how we can build on and extend Medicare, adapting it to gain the benefits of greater consumer choice and provider competition.

We agree that the starting point for reform must be Australia's unique health care system, with its own strengths. These strengths include universal health insurance funded out of general taxation revenue, a mix of public, not-for-profit and private providers of services, and a high level of uptake of private health insurance. The design of reformed governance arrangements will necessarily be influenced by these foundations, resulting in a uniquely Australian approach.

Reflecting this thinking, we have moved away from describing our model for governance reform as social health insurance, which is somewhat inaccurate and misleading. Our new model is based on the establishment of health and hospital plans. While the proposed reform draws upon some features of social health insurance, it also encompasses ideas of consumer choice and strategic purchasing which are features of other health care systems.²¹⁶

Again, the important point is that, in developing our model for governance reform, we are building on and extending our uniquely Australian health insurance system of Medicare. We are proposing introducing the opportunity for people to select a 'health and hospitals plan' of their choice to deliver on their Medicare entitlement. For this reason, we have given our governance model the working title 'Medicare Select'. A more detailed description of 'Medicare Select' is outlined in the next section.

6.6 'Medicare Select': building on and expanding Medicare

The overall aim of 'Medicare Select' is to improve the responsiveness and efficiency of Australia's health system, and its capacity for innovation, through three main levers:

- greater consumer choice;
- greater provider competition; and
- better use of public and private health resources.

In a nutshell, 'Medicare Select' is based on the establishment of health and hospital plans to deliver on their members' universal Medicare entitlement. All Australians would automatically belong to a government operated health and hospital plan, but could select to move to another plan, which could be operated by a not-for-profit or private enterprise. Health and hospital plans would receive funds from the Commonwealth Government on a risk-adjusted basis for each person. In effect, people would take their universal service entitlements under 'Medicare Select' – including their entitlement to Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) and public hospital care – to their plan. Through contracting arrangements with public and private providers, plans would purchase services to meet the full health care needs of their members. This would entail a strategic approach to innovative purchasing, focusing on people's health needs over time, and across service settings, rather than on the purchase of individual elements of the service.

In Table 6.2 below, we outline the features of the 'Medicare Select' concept in terms of arrangements for financing, funding, policy and regulation, purchasing and provision of health services. We emphasise that this is just an illustrative example of the arrangements as we recognise that more work is needed to fully develop the approach and test its feasibility in the Australian context.

Finally, we make the obvious point that, under 'Medicare Select', the Commonwealth Government would need to take direct responsibility for some health activities. It is likely that biosecurity, ambulance services, some public health activities (for example, communicable disease control and environmental health), and some highly specialised areas of medicine (for example transplant surgery) would be planned, funded and, in some cases, delivered by the Commonwealth Government. It would also maintain a significant role in fostering and funding research and supporting clinical education and training.

²¹⁶ G Mc Sorley (2007), "Strategic Purchasing: The Experience in England", Health care Papers (8): 77-92; European Observatory on Health Systems and Policies, J Figueras, R Robinson, E Jakubowski (eds) (2005), Purchasing to improve health systems performance, (Open University Press: Maidenhead, England).

Table 6.2: Illustrative model of 'Medicare Select'

Under 'Medicare Select', the **Commonwealth Government would be the sole government funder** of health services. There are a number of possible financing mechanisms. 'Medicare Select' could be financed from consolidated revenue. Alternatively, to aid the community's understanding of the cost of the universal entitlement to health care, it could be financed through a publicly identified share of consolidated revenue or from a dedicated levy.

The **Commonwealth Government would determine the universal service entitlement** and service obligation for all Australians.

All **Australians would automatically belong to a government operated health and hospital plan**, which could be a national plan, a plan operated by a state government or by a not-for-profit or for-profit organisation. **People could readily select to move to another health and hospital plan**, which could be another government operated plan, or a plan operated by a not-for-profit or private enterprise. Plans could not refuse a member.

Similar to Medicare now, health and hospital plans would cover a mandatory set of health services made explicit in a **universal service obligation**, which would include hospital and medical care and pharmaceuticals.²¹⁷

As is the case now with **private health insurance**, people could purchase from private health insurers additional coverage not included under the universal service obligation (such as for extended allied health coverage, advanced dental care, enhanced hospital amenity and access). Similarly, third party insurers would be retained.

Specific plans, such as those provided by the Department of Veterans' Affairs and the proposed National Aboriginal and Torres Strait Islander Health Authority, would remain available to those entitled. It is also possible that providers of health and hospital plans would provide a specific plan focusing on serving the needs of people living in remote areas of Australia.

The Commonwealth Government would distribute funds to health and hospital plans on a **risk-adjusted basis for each person**. That is, funding would follow the person and reflect the likely health needs of that person, based on factors such as age, known health risks and previous health service utilisation. In effect, people would take their universal service entitlements under 'Medicare Select' – including their entitlement to MBS, PBS and public hospital care – to their health and hospital plan. There may also be a risk equalisation mechanism supporting the risk adjusted payment approach.

Through contracting arrangements with providers, health and hospital plans would purchase the services to meet the full health care needs of their members. This would entail a **strategic approach to purchasing**, focusing on people's health needs over time, rather than on the purchase of individual elements of the service. They would have responsibility for the full continuum of health services under the universal service obligation.

Health and hospital plans would negotiate **contractual arrangements with both public and private providers**. In response to the incentives and requirements set by the contracting process, providers would compete to increase efficiency and quality – including access, patient satisfaction, and use of best knowledge and practice.²¹⁸ Strategic purchasing in the context of provider competition offers the promise of innovative approaches to improve patient care and service delivery.

The providers of health and hospitals plans would also have a **motivation to invest in wellness and prevention** to encourage and support members in healthy living, understand and manage health risks, intervene early and coordinate chronic and complex care needs over time.

217 While this outline of health and hospital plans focuses on health care, we note the advantages of possibly extending coverage to disability services. Access to disability services has been labelled a 'lottery', varying according to type of disability, how the disability was acquired, age of the person with a disability, as well as income and geographic location. Support is fragmented across program areas, multiple government departments and jurisdictions. (B. Bonyhady, 'Support in short supply for disabled', *The Australian*, 7 May, 2009.) In response to the suggestion at the 2020 Summit, the Government has agreed to consider the development of an insurance model to meet the costs of long term care for people with disabilities. (Australian Government 2009, *Responding to the Australia 2020 Summit*, at http://www.australia2020.gov.au/docs/government_response/2020_summit_response_full.pdf, p. 126.)

218 M Dusheiko, M Goddard, H Gravelle and R Jacobs (2006), 'Trends in health care commissioning in the English NHS: an empirical analysis', CHE Research Paper 11, Centre for Health Economics, York University, pp. 1-2.

Table 6.2: Illustrative model of 'Medicare Select' (continued)

The Commonwealth Government would be responsible for the policy and regulatory parameters for 'Medicare Select'. If the full benefits of choice and competition are to be realised, the Commonwealth Government must design **a policy and regulatory framework** which includes a number of key elements.²¹⁹

Importantly, there must be enough **alternative plans to allow for competition and consumer choice**. The Government would need to develop regulation governing the establishment and operation of health and hospital plans. The regulatory standards would influence the numbers of plans that could operate efficiently in the Australian market.

For the market to be truly competitive, consumers would need to be able to change plans with relative ease. **Funding must follow the choices of individuals**. The threat of consumers switching plans would place pressure on health and hospital plans to 'perform'.

The Commonwealth Government would have a very important role in establishing a **regulatory framework to control and monitor** health and hospital plans. Mechanisms such as sound risk equalisation, a consumer ombudsman and requirements that plans must accept all members should address potential 'cream skimming'. Co-payments for mandatory coverage would also be limited by regulation. There would also be **accountability and performance monitoring arrangements** for plans set by the Commonwealth Government, such as access targets, quality indicators and performance benchmarks.

6.6.1 Key benefits of 'Medicare Select'

Potentially, 'Medicare Select' would have a number of benefits.

Under 'Medicare Select', both the Commonwealth and state governments could retain a significant presence in health care, but with rational allocation of roles and responsibilities. The Commonwealth Government would be responsible for setting the policy parameters, financing the national program, establishing appropriate accountability arrangements, managing risk adjusted funding, and regulating health and hospital plans and contracting arrangements. The Commonwealth Government would also operate a health and hospital plan. The states could retain responsibility for the provision of public hospital and other health services, and could also operate a health and hospital plan.

'Medicare Select' would retain a mixed public and private system of financing and service provision, reflecting community preferences. But the private sector would be embedded in the national system, allowing better use of both public and private health resources.

Under 'Medicare Select', universal coverage of people and their families would be maintained, and even strengthened with consumer choice of health and hospital plan. Health plans would be responsible for caring for people's full health needs – potentially having responsibility for the whole of a person's care throughout life – providing strong incentives to focus on prevention, health coaching for healthy behaviours, and better management of chronic diseases through early intervention, service integration and coordination.

Through strategic purchasing, health and hospital plans would encourage innovative approaches to funding aimed at improving patient care and service delivery. Competition for contracts would, in turn, place pressure on service providers to improve the quality and efficiency of care.

We agree that a single payer for each person with flexibility and incentives to purchase the most cost-effective services would be an important governance reform. Consistent with this, under 'Medicare Select', plans could develop flexible and innovative approaches to attracting membership from people living in rural and remote areas – for example, by including coverage for telehealth and patient travel.

219 Prime Minister's Strategy Unit 2006, *The UK Government's Approach to Public Service Reform – A Discussion Paper*, Cabinet Office, London, p. 47.

In summary, 'Medicare Select' – driven by consumer choice, competition, and the best use of the public and private health resources – has the potential to create a more dynamic system, encouraging continuous improvement in the health system in response to future challenges.

It would provide the mix of drivers required for a self-improving public health system:

- pressure from the top, with government determining the strategic direction, standards and regulation, as well as accountability and performance management arrangements;
- horizontal pressure, with competition and contestability for providers on the supply side; and
- bottom-up pressure, with increased consumer choice on the demand side.²²⁰

As one submission concluded:

“ Above all, it would lead us closer to a health system that actually works as a *SYSTEM* rather than as a series of disjointed silos and structural relationships embodying perverse incentives. ²²¹

While agreeing that 'Medicare Select' offers a number of potential advantages, we recognise that there are complex issues and potential risks that must be thoroughly evaluated and resolved. As an indication of the scope of these issues, they include:

- the type and extent of services covered under the universal service obligation;
- the financial transfers between state, territory and local governments and the Commonwealth Government required to achieve a single national pool of public funding to be used for funding health and hospital plans;
- the basis for raising financing for health and hospital plans, including the extent to which transparency should be promoted through use of a dedicated levy or through publicly identifying the share of consolidated revenue that makes up the universal service obligation;
- the approach to ensuring equitable access to health services in areas of market failure, particularly in remote and rural areas of Australia;
- the regulatory framework to support the establishment and operation of health and hospital plans;
- balancing the ease of movement in and out of funds with the need to give plans a long-term incentive to invest in the health and wellness of their members;
- ensuring consumers have access to adequate information so that it allows them to make an informed choice about plans; and
- equitable and viable methods of funding health and hospital plans based on members' risk in terms of factors such as age, known health risks and previous health service utilisation.

More work is needed to fully develop 'Medicare Select' and test its applicability to the Australian context. We therefore recommend 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 issues that would need detailed examination are listed in the recommendation below.

220 Prime Minister's Strategy Unit 2006, *The UK Government's Approach to Public Service Reform – A Discussion Paper*, Cabinet Office, London, Chapter 4. This model of public service reform also includes measures to improve the capability and capacity of the workforce. These issues are discussed in Chapter 5.

221 H Owens (2009), Submission 250 to the National Health and Hospitals Reform Commission: Second Round Submissions.

89. We believe that there is a real need to further improve the responsiveness and efficiency of the health system and capacity for innovation. We agree that greater consumer choice and provider competition and better use of public and private health resources could offer the potential to achieve this, through **the development of a uniquely Australian governance model for health care that builds on and expands Medicare**. This new model is based on the establishment of health and hospital plans, and draws upon features of social health insurance as well as encompassing ideas of consumer choice, provider competition and strategic purchasing. We have given this new governance model the working title 'Medicare Select'.
90. We recommend that the Commonwealth Government commits to explore the design, benefits, risks and feasibility around the potential implementation of **health and hospital plans** to the governance of the Australian health system. This would include examination of the following issues:
- 90.1 The basis for determination of the **universal service entitlement** to be provided by health and hospital plans (including the relationship between the Commonwealth Government and health and hospital plans with regard to growth in the scope, volume, and costs of core services, the process for varying the level of public funding provided to the health and hospital plans for purchasing of core services; and the nature of any supplementary benefits that might be offered by plans);
- 90.2 The scope, magnitude, feasibility and timing of **financial transfers** between state, territory and local governments and the Commonwealth Government in order to achieve a single national pool of public funding to be used as the basis for funding health and hospital plans;
- 90.3 The basis for **raising financing for health and hospital plans** (including the extent to which transparency should be promoted through use of a dedicated levy or through publicly identifying the share of consolidated revenue that makes up the universal service entitlement);
- 90.4 The potential impact on **the use of public and private health services** including existing state and territory government funded public hospitals and other health services (incorporating consideration of whether regulatory frameworks for health and hospital plans should influence how plans purchase from public and private health services including whether there should be a requirement to purchase at a default level from all hospitals and primary health care services);
- 90.5 The approach to ensuring **an appropriate level of investment in capital infrastructure in public and private health services** (including different approaches to the financing of capital across public and private health services and the treatment of capital in areas of market failure);
- 90.6 The relationship between the health and hospital plans and the continued operation of the **Medicare and Pharmaceutical Benefit Schemes** (including whether there should continue to be national evaluation, payment and pricing arrangements and identifying what flexibility in purchasing could be delegated to health and hospital plans concerning the coverage, volume, price and other parameters in their purchasing of medical and pharmaceutical services in hospitals and the community);
- 90.7 The **potential role of private health insurance** alongside health and hospital plans (including defining how private health insurance would complement health and hospital plans, the potential impact on membership, premiums, insurance products and the viability of existing private health insurance; and any changes to the Commonwealth Government's regulatory, policy or financial support for private health insurance);
- 90.8 The **potential roles of state, territory and local governments** under health and hospital plans (including issues related to the handling of functions such as operation of health services, employment of staff, industrial relations and the implications for transmission of business and any required assumption of legislative responsibility by the Commonwealth Government related to these changed functions, together with the operation by state and territory governments of health and hospital plans);
- 90.9 The range of **responsibilities and functions to be retained or assumed by Australian governments** (and not delegated to health and hospital plans) in order to ensure national consistency or to protect 'public good' functions (including, as potential examples, functions such as health workforce education and training, research, population and public health and bio security);

- 90.10 The approach to **ensuring equitable access to health services in areas of market failure including in remote and rural areas of Australia** (including the relevant roles of health and hospital plans in regard to the development and capacity building of a balanced supply and distribution of health services, and the approach by plans to regional and local consultation and engagement on population needs);
- 90.11 The necessary **regulatory framework** to support the establishment and operation of health and hospital plans (including issues relating to entry and exit of plans, minimum standards for the establishment of plans, any requirements relating to whether plans are able to also provide health services, and the potential separation of health and hospital plans and existing private health insurance products);
- 90.12 The development of **appropriate risk-adjustment mechanisms** to protect public funding and consumers (including potential mechanisms such as the use of risk-adjusted payments by the Commonwealth Government to health and hospital plans, reinsurance arrangements and risk-sharing arrangements related to scope, volume and cost of services covered under health and hospital plans); and
- 90.13 The necessary **regulatory framework to protect consumers** (including potential requirements around guaranteed access, portability, co-payments, information provision on any choices or restrictions relating to eligible services and health professionals/health services covered under individual health and hospital plans, measures to regulate anti-competitive behaviours and complaints mechanisms).

CHAPTER 7

IMPLEMENTING A NATIONAL PLAN FOR HEALTH REFORM



7. Implementing a national plan for health reform

“ There is no shortage of excellent health policies in the Australian health system – the problem is implementation, not policy.²²²

7.1 Committing to health reform

The task of implementing major reform of Australia's health system may seem daunting. But it is worth recalling that the Commonwealth Government implemented Medicare in less than two years and the Victorian Government implemented activity-based funding for public hospitals in just five months. In both cases, the governments had a strong commitment to reform in the face of an urgent need for action. We have argued in this report that Australia again faces an urgent need for reform of our health system. Our health care system is under pressure from many quarters:

- significant increases in demand for, and expenditure on, health care due to many factors, including advances in medical technology, an ageing population, the increase in chronic disease, and the increase in consumer expectations;
- unacceptable inequities in health outcomes, particularly the gap in health outcomes for Aboriginal and Torres Strait Islander people;
- lack of access to health services for many people, particularly people with a mental illness, people in remote and rural Australia, and low-income people in need of dental care;
- growing concerns about quality and safety;
- problems with the availability, mix and distribution of the health workforce; and
- high levels of inefficiency, including administrative inefficiency (for example, business processes and bureaucracy), operational inefficiency (for example, poor use of data and information and medical errors), and allocative inefficiency (for example, inappropriate emphasis on acute care and lack of cost effectiveness of interventions).²²³

Addressing these pressures on the equity, efficiency and sustainability of our health system will require the leadership of all Australian governments. A clear message of our recommendations is that we need to move in many areas to 'one health system', with a national approach to many key policies and governance functions. To achieve reforms at a national level, leadership falls most squarely with the national government. But Australia does not have a single government with responsibility for health policy, programs and funding, and reform of health care will require the leadership and commitment of the states as well. That is why we see a new national health agreement – the Healthy Australia Accord – between the Commonwealth and state governments as fundamental to implementation of many of the reforms that are needed to give Australians the health system they deserve for the 21st century.

In this final chapter, we turn to these practical issues of leading and managing change, and consider an implementation plan for our recommended reforms, and the financial implications of, and gains from, our reform agenda.

7.2 Implementing reforms

Our reforms cover a wide range of initiatives of differing degrees of implementation difficulty – from increased funding for health services research and oral health promotion, to implementing a national e-health system and the Commonwealth Government taking full responsibility for primary health care. While we agree this is an ambitious reform agenda, we note that it is not unusual for the Commonwealth Government or a state government to pursue initiatives across many different areas simultaneously within a portfolio. Governments' annual budget documents provide evidence of this.

222 N Argall (2008), Submission 366 to the National Health and Hospitals Reform Commission: First Round Submissions.

223 National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, at: www.nhhrc.org.au

Furthermore, there are clearly different types of initiatives within our reform agenda which allow different approaches to taking action. For the purposes of implementation, our reforms fall into three broad categories:

1. **Reforms which are essentially within the ambit of one level of government** – for example, reshaping the Medicare Benefits Schedule and expanding choice in aged care, both of which are the responsibility of the Commonwealth Government;
2. **Reforms which realign roles and responsibilities between the Commonwealth Government and the state governments**, such as the Commonwealth Government having full responsibility for the policy and government funding of primary health care and basic dental care. These reforms will be set out in the new Healthy Australia Accord; and
3. **Reforms which are longer term in nature** and require further investigation and/or development. These include the exploration of the design, benefits, risks and feasibility around the potential implementation of 'Medicare Select'.

Within these categories, there are some reforms that are dependant on others, and so need to be implemented sequentially. This is true of several of the reforms in aged care – for example, the alignment of subsidies and fees across community and residential care is a necessary precursor to allowing people greater choice as to whether to use their care subsidy at home or in a residential aged care service. Other initiatives are essentially stand-alone. Understanding the degree of connections between initiatives will help plan implementation.

In Appendix G, we have put forward a high level action plan which addresses key elements of implementation. As more detailed planning and implementation work is undertaken, there may be sound reasons for altering the plan. The plan:

- sets out for every recommendation our suggestions as to who should lead or instigate the reform, who should be responsible for doing it and, in some cases, the timing of reform;
- identifies those recommendations that require changes to government responsibilities and/or federal funding arrangements, as a guide to what will need to be addressed under the Healthy Australia Accord;
- identifies where legislative change may be required; and
- outlines in greater detail some of the areas of reform where staging of action is required.

Generally, in terms of timing, we believe that – wherever possible – steps should be taken to commence development and take action on each reform or set of reforms in the first year. Implementation should be regarded as commencing with government endorsement of reform. Furthermore, we believe that most of the reforms we have proposed in categories 1 and 2 – that is, reforms which are either essentially within the ambit of one level of government (category 1), or which realign roles and responsibilities between the Commonwealth Government and the state governments (category 2) – could be substantially achieved within three to five years, with some able to be implemented sooner than this. Work to introduce most of those reforms which are within the ambit of one level of government could also commence immediately.

7.2.1 Leading reform

To give effect to a national health system, we are calling on First Ministers to agree to a new Healthy Australia Accord that will clearly articulate the agreed and complementary roles and responsibilities of all governments in improving health services and outcomes for all Australians.

The first step towards this should be for the Council of Australian Governments (COAG) to agree in 2009 to develop the new Healthy Australia Accord – consistent with our recommendations in Chapter 6. The aim should be to agree the Healthy Australia Accord in 2010. To accelerate the pace of reform, one option would be for the Accord to be a high level agreement, supported by more detailed individual agreements on specific reform elements. This would allow early action on some reforms while others were still being developed.

In parallel, we recommend that over the next two years the Commonwealth Government explores the concept of 'Medicare Select' including the design, benefits, risks and feasibility of introducing 'health and hospital' plans.

From our experience over the past 16 months, we are certain that there is a genuine desire for reform of Australia's health system. Our existence as a Commission, and the endorsement of our terms of reference by all governments, demonstrates governments' acceptance that improvements to Australia's health system are needed. Moreover, based on our consultations both in meetings and through the submissions we have received, we know the community, health professionals and health services are also ready to embrace reform.

We urge governments to continue consultation and engagement with the community, health professionals and health services – successful implementation of the reform agenda will depend upon it. Change is more easily achieved, and with better results, when it is informed by the views and with the active involvement of those affected.

7.3 Accountability for reform

Accountability is also critical to successful change. Many of the reforms we have proposed are intended to clarify and strengthen accountability for the performance of the health system and of health services. This is true of our proposals to change the allocation of responsibilities between governments; to improve measurement of service performance, with funding to be increasingly linked to performance; and to improve public reporting of quality and performance at the service and the system level.

We believe there must also be clear accountability for implementation of reform. For many of our reforms, the Healthy Australia Accord provides a basis for this at the highest level – heads of governments. Progress of the reforms in the Healthy Australia Accord should be monitored and publicly reported by the COAG Reform Council – the independent agency established by the Council of Australian Governments to monitor and report on the performance of governments against national reform agreements. For our recommended reforms that do not require an inter-government agreement, we urge the responsible government or governments to set out a timeframe for their implementation and commit to reporting against this. In addition, we propose that the Commonwealth Government draw on a national Clinical Senate (see Section 5.2.1) to provide continuing advice on the implementation of reform and appropriate measures of performance and outcomes. However, accountability must go beyond ensuring adherence to the implementation of agreed reforms within a specified timeframe. Ticking off an agreed list of reforms as they are implemented is not sufficient.

The real measure of success will be a demonstrably better health system, both in a technical sense – such as improved access to health services – and according to those who rely on it and those who work within it. That is why we believe that there should be three measures of success of our health system: measures of the performance of the health services, of the public's confidence in the health system, and of the satisfaction of those working within it.

Performance against these three measures should be regularly monitored and publicly reported. Reporting should be at the national, state and local service level. Reporting should also reflect how well the health system meets the needs of the most vulnerable people and those hardest to reach, including people living in rural and remote areas, the socially and economically disadvantaged, and Aboriginal and Torres Strait Islander people.

Transparency is linked to accountability. Many people mistakenly believe that the Medicare levy of 1.5 per cent of taxable income funds total Commonwealth expenditure on health care. But in fact it represents about 18 per cent of the Commonwealth's total spending on health care, and only about 8 per cent of the total spending on health care from all sources including by governments, through private health insurance and directly by us as individuals.²²⁴ As we discussed in Section 4.3.3, being open and clear about how much it costs to have access to universal health services would help create greater transparency and community understanding about spending on health.

224 Commonwealth Government (2007), Budget Paper No. 1, Budget Strategy and Outlook 2007-08, Statement 5: Revenue, p. 5-9; Australian Institute of Health and Welfare (2008), Health Expenditure Australia 2006-07, p. 20 (Australian Institute of Health and Welfare: Canberra).

7.4 Investing in reform – assessing the financial implications

This section considers the financial implications of our proposed initiatives – or, to put it another way – the investment required to achieve reform of Australia's health system.

We consider the financial implications of our proposed reforms from three perspectives:

- the recurrent and capital costs of major reforms;
- the impact on health expenditure over the medium to long term; and
- the gains to efficiency and productivity.

7.4.1 Recurrent and capital costs of major reforms

We have estimated the indicative costing of those of our reforms that entail significant additional expenditure (see Appendix H). The additional costs in a full year of these reforms to Australia's health system (excluding 'Dentcare Australia') are between \$2.8 billion and \$5.7 billion (see Table 7.1).

These figures include indicative costs for improved public dental care, but not for the 'Dentcare Australia' scheme which is considered separately. Once fully implemented, 'Dentcare Australia' would see the transfer to the Commonwealth Government of responsibility for funding of \$3.6 billion per year, which is currently spent privately through private health insurance or directly by consumers. We have suggested this, and an increase in spending to meet unmet need, could be offset by an increase in the Medicare levy of about 0.75 per cent of taxable income. Many people would pay less for dental care under 'Dentcare Australia'.

In addition, an investment in capital over five years of between \$4.3 billion and \$7.3 billion would be required to transform the health system's infrastructure to enable our reforms (see Table 7.2). Capital investment is a critical enabler of a number of our transformative reforms – including delivering an e-health agenda, strengthening primary health care, and reforming dental care. Capital can drive change and is fundamental to achieving the efficiencies and reorientation of the health care system we are recommending. Short term capital investment will be vital to reshaping how care is delivered, filling service gaps, building new systems and capabilities and stimulating change.

Appendix H sets out the basis for these estimates. We draw attention below to a number of important points in understanding the overall basis of our estimates:

- recurrent costs are indicative estimates of full year expenditure;
- some recommendations have no additional costs as governments have already committed to fund similar areas of focus. For example, COAG has agreed to fund a number of initiatives similar to those proposed under our Healthy Start strategy, and the Commonwealth Government has committed \$1.58 billion in funding for improved health services for Aboriginal and Torres Strait Islander people under the 'Closing the Gap' strategy;
- where we have recommended the continuation of an existing activity that has time limited funding – such as the Australian Commission on Safety and Quality in Health Care or the Elective Surgery Waiting List Reduction Plan – we have included the ongoing cost of the activity in our estimates of expenditure; and
- however, where the initiatives we have proposed differ from an existing or new function or service to which government has committed we have noted the additional costs. For example, our recommended National Health Promotion and Prevention Agency has a broader remit than that proposed by the government so we have estimated the additional funding required.

Table 7.1: Indicative costs of reform recommendations

Reforms	Range of costs (savings/revenue)	
	\$m	\$m
Prevention	100	100
National Health Promotion and Prevention Agency	100	100
Supporting healthy workers*		
Primary Health Care	883	1962
C'wth responsibility funding & policy primary health care#		
Enrolment of young families, Indigenous people, the chronically ill	341	682
PHC prevention, access and quality performance payments	252	800
Primary Health care organisations	150	150
Reshaping MBS	140	330
Targeted antenatal care*		
Core contacts for child & family health*		
Hospitals	(138)	917
National performance reporting & accountability framework	12	12
National activity-based hospital funding	(1330)	(570)
Nationals Access Targets and Hospitals/ED	720	1015
Enhanced sub-acute care services/aids and equipment	460	460
Aged Care	874	1323
Expanding provision of aged care subsidies	530	838
More flexible range of community aged care subsidies	296	437
Medical arrangements with residential aged care services	48	48
Advance care planning training		
Health and health care for Indigenous people	70	70
Aboriginal & Torres Strait Islander healthy nutrition funding	12	12
National Aboriginal & Torres Strait Islander Health Authority	58	58
Rural and remote	217	514
Equivalence funding in remote and rural areas	55	143
Remote & rural outreach, telehealth & advice networks	50	100
Rural workforce enhancement package	27	27
Patient travel assistance	85	244
Mental Health	356	356
Communities of youth services	30	30
Early psychosis prevention and intervention services	26	26
Rapid mental health response teams	200	200
Sub-acute mental health services	70	70
Employment support for people with mental illness	7	7
Mental health and dementia support for older Australians	23	23
Dental Care and Oral Health	320	320
Dental Residency program	200	200
School dental expansion	100	100
Oral health promotion	20	20
Workforce		
New clinical education and training framework*		
National education and training agency*		
National professional registration*		
Aboriginal & Torres Strait Islander health and professional training*		
Increasing training places in remote & rural areas*		

Table 7.1: Indicative costs of reform recommendations (continued)

Reforms	Range of costs (savings/revenue)	
	\$m	\$m
One national health system	167	167
Clinical, health services and health policy research	100	100
National health innovation	8	8
Australian Commission for Safety and Quality in Health Care	34	34
National health intervention & private hospital regulation	25	25
Total	2849	5729

* COAG funding noted

Entails shift of about \$4 billion from states to Commonwealth

Table 7.2: Estimated capital requirements (over 5 years)

Reforms	Range of costs (\$m)	
Primary Health Care		
Comprehensive PHC Centres and Services	300	300
Hospitals		
Enhanced sub-acute care services	900	1500
Hospitals reshaping	1250	2500
Mental Health		
Communities of youth services	30	30
Dental Care and Oral Health		
Dental residency program	375	750
School dental expansion	125	250
Workforce		
Clinical education & training facilities (across all settings and including rural)	100	150
One national health system		
National e-health agenda	1185	1865
Total	4265	7345

In considering these recurrent and capital implications of reform, it is important to note that this investment would be across both Commonwealth and state governments to varying extents for different reforms.

Also changes to the actual level of expenditure in any one year from our reforms will depend on the pace of the implementation of the reforms. If phased in over several years, as we anticipate, the impact on expenditure in any one year could be quite modest.

Furthermore, as set out later in this chapter, these indicative estimates of the recurrent costs of the specific recommendations do not take into account the potential of a number of the reforms to contain health expenditure and increase productivity, while improving people's health and providing a better, more effective mix of services. Overall, modelling by the Australian Institute of Health and Welfare indicates that elements of our proposed reforms will result in lower growth in health expenditure in the medium to long term.²²⁵

225 Australian Institute of Health and Welfare (2009), Estimates of the impact of selected NHHRC reforms on health care expenditure, 2003 to 2033, (AIHW: Canberra).

7.4.2 Gains from the investment

As for any investment, it is important to keep in mind what we are aiming to achieve.

Through this investment, we are aiming to transform the Australian health care system by:

- tackling the major access and equity issues that affect people now;
- redesigning our health system to meet emerging challenges; and
- creating an agile and self improving health system for the future.

Appendix H identifies the indicative costs of our major reforms. Here we highlight the gains from our investments:

- **prevention** would become a high priority, with education, evidence and research driven by the National Health Promotion and Prevention Agency;
- through support for the achievement of **National Access Targets**, people's timely access to public hospitals and health services would be improved across the care continuum – acute care, emergency care, specialist care, primary health care, community health services, aged care, and diagnostic services;
- **primary health care** would be embedded as the cornerstone of our health system, reinforcing prevention, early intervention, and connected care;
- young families, Aboriginal and Torres Strait Islander people, and people with complex and chronic needs would have a '**health care home**' through voluntary enrolment with a primary health care service;
- a **healthy start to life** for all children would be supported, through universal and targeted services;
- for the first time, **universal access to basic dental services** would be provided, addressing a key area of both health need and health inequity;
- for **people with a mental illness**, to improve their health and wellbeing and reduce the need for crisis care, the focus would shift to early intervention, better management of mental health disorders, and better support;
- the approach to funding of health services for **Aboriginal and Torres Strait Islander people** would be radically changed, to actively purchase and commission the very best care;
- improved services, support and equivalent funding for people in **remote and rural** Australia would be introduced, to redress a basic inequity in access to our 'universal' service entitlement;
- adequate, responsive **aged care services** would be ensured for the increasing numbers of older people;
- **hospitals of the future** would be created, specialist services in the community would be expanded, and sub-acute services – the 'missing link' – would be increased;
- the **education and training** – and continuing education – of our health professionals would be improved;
- a **national e-health agenda**, including a **person-controlled electronic health record**, would be delivered to enable people to take a more active role in managing their health and making informed health care decisions, improve clinical decision making, reduce medical errors, and improve productivity; and
- a 'self improving' health system would be driven by the establishment of a **permanent national safety and quality commission**, adequate funding for **research** – including health services, public health and health policy research – and the availability of '**smart data**' on **clinical quality and health system performance**.

While we have highlighted a number of major investments, it is important to emphasise that the level of expenditure is not necessarily a yardstick for the significance of a recommended reform. For example, transferring funding and policy responsibility for primary health care from the states to the Commonwealth Government does not require increases in expenditure. Over time, however, we believe it will enable the transformation of the delivery of primary health care, particularly through more comprehensive, better integrated and coordinated care.

7.4.3 The impact on health expenditure over the medium to long term

Estimating the increased government recurrent and capital expenditure is one way of assessing the financial implications of our reforms. But it has its limitations, focusing just on the immediate costs. It does not take full account of the improvements in performance and efficiency that will be achieved in the medium to longer term through better provision of more appropriate services as a result of the reforms. Assessing the value of the recommended reforms is more complex, requiring an understanding of their full costs and benefits over the medium to longer term.

To take one example: investing in a healthy start to life and strengthening primary health care as the foundation of our health care system are key strategies for both reorienting health care to wellness and prevention, and rebalancing and connecting care for people over their lifetime. This set of reforms will require significant expenditure, particularly due to the costs of additional services for families with young children, Aboriginal and Torres Strait Islander people, the chronically ill, and people with disabilities through voluntary enrolment.

But this is just the cost side of the balance sheet. This investment in primary health care will improve the health and wellbeing of many, many thousands of Australians. For example, better access to primary health care will mean reductions in obesity and smoking and earlier and better treatment of chronic diseases, such as diabetes. In the medium to longer term, these impacts will flow through to reductions in other diseases, particularly cardiovascular diseases, and hence reductions not only in mortality and morbidity but also in more expensive acute hospital care. Thus, in the medium to longer term, these reforms will reduce growth in projected health expenditure. Indeed, the Australian Institute of Health and Welfare (AIHW) has estimated that the introduction of patient enrolment with a primary health care service will save \$380 million a year by 2022–23 and \$635 million a year by 2032–33.²²⁶

While it is complex to attempt to fully assess the costs and benefits of investment, we believe it is important to do so to give people a more complete picture and understanding of the gains from the additional investment we are recommending.

To do this, we commissioned the AIHW to estimate the impacts of our key recommended reforms on health expenditure over the medium to long term. In summary, modelling by AIHW suggests our reforms would result in lower costs overall in the medium to longer term. The impacts considered were:

- strengthening of primary care services through patient enrolment;
- more sub-acute care and subsequent reduction over time in the proportion of hospital bed days which are for acute care;
- increase in aged care places;
- improved treatment of diabetes;
- reduced rate of increase in obesity rates;
- faster decline in smoking rates;
- implementation of 'Denticare Australia';
- implementation of personal electronic health records; and
- improvements in safety and quality of care.

The AIHW estimated the impacts of our key reforms on factors such as changes in disease rates, number and type of services received (for example, admitted or primary health care), and the proportion of people who receive treatment.

Table 7.3 compares the AIHW's current projections of health and residential aged care expenditure in 2022–23 and 2032–33 with the projected expenditure after taking account of the impacts of our key reforms. According to the AIHW, our key reforms will reduce projected spending by \$4 billion a year by 2032–33. As a proportion of GDP, health and aged care expenditure will be 12.2 per cent of GDP in 2032–33, which is less than the projected 12.4 per cent.

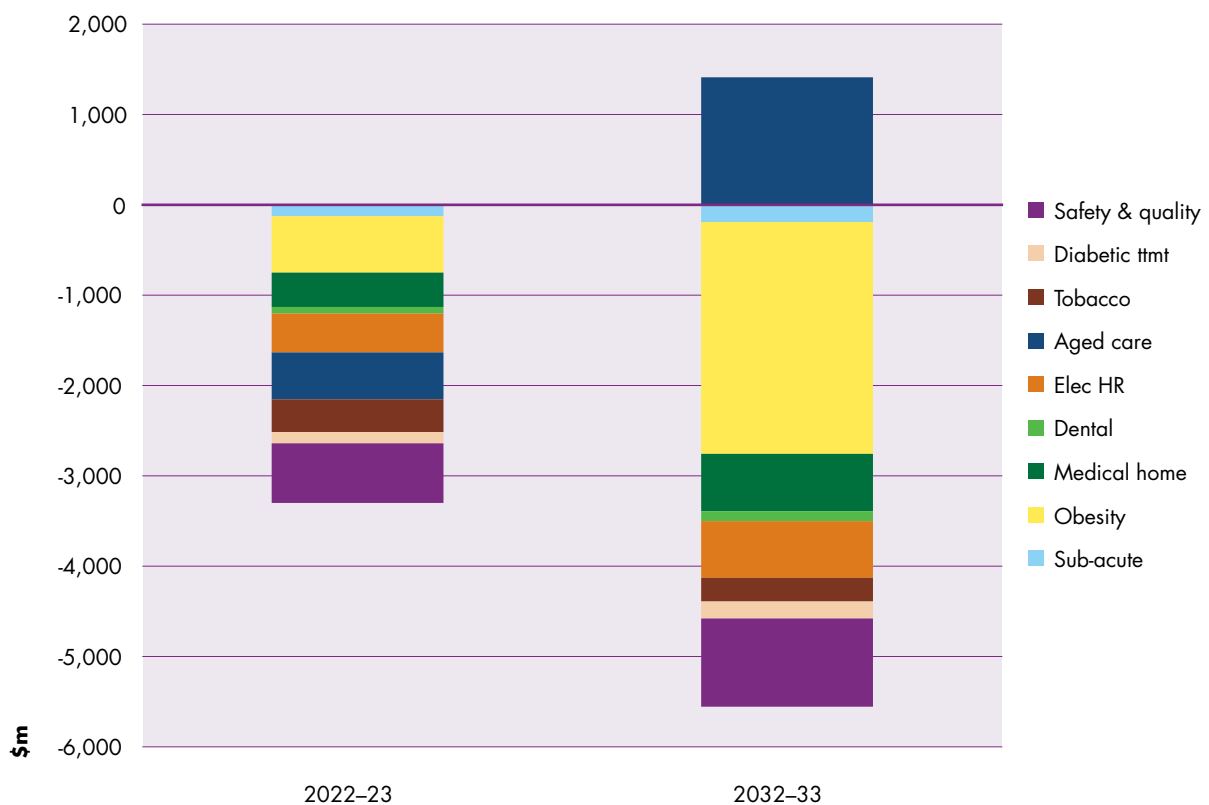
²²⁶ Australian Institute of Health and Welfare (2009), Estimates of the impact of selected NHHRC reforms on health care expenditure, 2003 to 2033, (AIHW: Canberra).

Table 7.3: Estimated changes in projected health and residential aged care expenditure due to reforms

	Expenditure (millions of 2006–07 dollars)		
	2002–03	2022–23	2032–33
Current projections of health & residential aged care expenditure (\$m)	85 063	167 729	246 056
Current projected expenditure as per cent of GDP	9.3%	10.6%	12.4%
Less net savings due to impact of reforms (\$m)			
• Improved availability of sub-acute care		-127	-190
• Reduced rate of increase in obesity		-624	-2 566
• Faster decline in smoking rates		-363	-262
• Patient enrolment with a primary health care service		-380	-635
• Reforms to aged care		-519	1 412
• Improved access to basic dental care		-73	-110
• Improved treatment of diabetes		-125	-188
• Implementation of personal electronic health records		-430	-627
• Improved safety and quality of care		-660	-976
Total		-3 301	-4 142
Revised projections of health & residential aged care expenditure (\$m)	85 063	164 428	241 914
Revised projected expenditure as per cent of GDP	9.3%	10.4%	12.2%

Figure 7.1 shows these in graphical form.

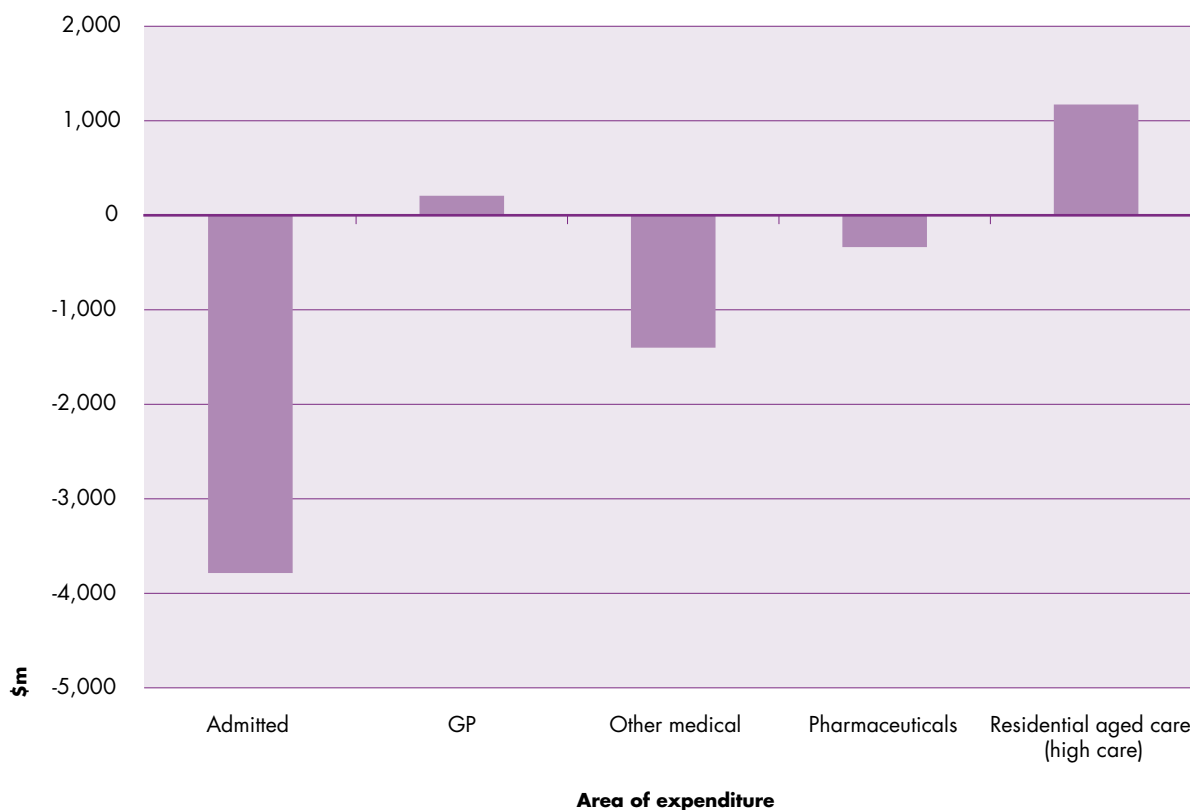
Figure 7.1: Estimated changes in total expenditure as a result of selected reforms, in 2022–23 and 2032–33, (\$ millions)



Looking behind the figures gives a better understanding of the estimated impacts of our reforms. Figure 7.2 illustrates the impacts of selected reforms on the balance of expenditure between services, showing, for example, that expenditure on primary medical care (GPs) and residential aged care are expected to increase as a result of our reforms, while expenditure on admitted patient care, other medical services (including specialist medical care outside hospitals) and pharmaceuticals will decrease, relative to projected spending in the absence of these reforms.

Overall, there is a shift in the balance of expenditure from admitted care to primary health care and/or residential aged care, improving the allocative efficiency of the health system.

Figure 7.2: Shifts in projected expenditure between services by 2032–33, flowing from aspects of our recommended reforms (\$m).



Overall, the AIHW's analysis indicates that the net effect of our reforms would be to reduce the burden of disease and deliver a better mix of more accessible and effective services at a lower cost and higher productivity within (or under) the projected increase in expenditure that would occur without these reforms. In other words, investing in these reforms now will deliver greater value for the community in the future.

7.4.4 Gains to efficiency and productivity

Another way of assessing the financial implications of our reforms is to focus on the gains to efficiency. As the background paper on efficiency prepared for the Commission notes:

“ The efficiency of the health care system is important, not only because it is key to delivering an affordable and sustainable health system, but also because it can be an ethical issue in terms of equity and fairness. If waste occurs – whether through duplication, poor processes, unnecessary high cost inputs, errors, too much administration, spending on treatments that were not needed or unlikely to improve outcome or could have been provided with an equivalent or better outcome in a lower cost way – it will adversely impact other people’s access to health care in a system with finite financial, capital and human resources.²²⁷

We have proposed a number of reforms to improve the efficiency of the health system, notably:

- using **activity-based funding** to drive the efficient delivery of public hospitals, public health services and clinical education;
- using **economic assessments of the cost effectiveness of interventions** to ensure funding goes to those interventions that will deliver the best outcomes for a given level of resources;
- **performance-based payments** to encourage and reward best practice and high quality outcomes;
- a **rebalancing of the type of interventions** delivered so that fewer people become ill and to ensure that when people need care they can receive the most appropriate service; and
- **delivering an e-health agenda** based on personal electronic health records, better use of data, communication and knowledge-led decision support.

In general, the efficiency gains of these reforms have not been separately identified. However, we do have estimates for two reforms: the introduction of activity-based funding and the implementation of personal electronic health records. Looking more closely at these two initiatives illustrates the significance of the efficiency gains for Australia’s health system from our reforms.

The introduction of activity-based funding will achieve efficiency gains because it will drive changes in behaviour, by:

- explicitly linking funds allocated to the services provided;
- making it possible to compare similar/peer hospitals;
- making it easier to determine if benchmarks have been met; and
- helping managers and clinicians to identify inefficient practices, allocate more resources to under-funded activities, control costs, and target unnecessarily high costs.²²⁸

We have estimated that, when fully implemented, activity-based funding of public hospitals and public health services, as recommended in this report, could save an estimated \$570 million to \$1,330 million a year.

227 National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, Background paper prepared for the National Health and Hospitals Reform Commission.

228 National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, Background paper prepared for the National Health and Hospitals Reform Commission.

In terms of the implementation of personal electronic health records, efficiencies are expected to be delivered across all health service settings. Efficiencies would be gained by minimising the need to:

- transcribe medical records;
- wait for paper records to be delivered; and
- re-order tests and diagnostic imaging – the test results and x-rays/scans could be attached to the personal electronic health record.

Adverse events are also expected to be reduced as, with a personal electronic health record, it will be easier to manage medicines (and their interactions) and medical histories (including, for example, allergies).²²⁹ The AIHW has estimated that the introduction of personal electronic health records would save an estimated \$430 million in 2022-23 and \$627 million in 2032-33 (see Table 7.3 above).

Activity-based funding and electronic health records target operational efficiency – that is, they impact on the use of resources in the production and delivery of services. Allocative efficiency is also very important in health care – it is concerned with ensuring the best allocation of resources so that the inputs allocated to the health system yield the best possible outcomes.²³⁰

A number of our reforms are concerned with improving allocative efficiency – including increasing the provision of sub-acute care, reforming aged care provision, implementing advance care planning, and shifting towards prevention and early intervention.

One way of measuring the gains to allocative efficiency is by estimating the number of additional bed days made available from avoiding or reducing the time spent in hospital. Considering the impact of three reforms – increased sub-acute services, improved access to aged care, and advance care planning – there would be significant additional bed days made available in hospitals, estimated at a minimum of 1,064,000 to a maximum of 1,341,000 bed days (see Appendix H). These reforms would translate to ‘freeing up’ about 2,900 hospital beds for other more appropriate use, including meeting relevant National Access Targets. This provides the capacity to provide 160,000 or more episodes of acute care to treat people requiring an overnight hospital stay.

7.5 Conclusions

This chapter has focused on practical issues of implementation, considering an implementation plan for our recommended reforms, and the financial implications of the reforms. We have highlighted the urgency of reform and argued that the implementation of reforms should begin immediately. We have also estimated the recurrent and capital costs of our reforms, while pointing out that, over the medium to long term, our reforms are estimated to reduce projected growth in spending on health and aged care.

Some may query the wisdom of undertaking significant reform of health care, and incurring increased expenditure, at a time when Australia’s economy and government outlays are under pressure from a global financial downturn.

But a healthy population and an efficient and effective health care system are essential to maximising the wellbeing of our nation, and the productivity of our economy and workforce.²³¹ Our recommendations for reform are aimed at achieving an improved distribution of resources to provide more efficient and effective health care over the next five to ten years. Improving the performance of a sector that represents a tenth of our economy – and which is expected to grow to become an eighth of our economy in the next twenty years – is essential to proper economic management.

229 National Health and Hospitals Reform Commission (2009), *The Australian health care system and the potential for efficiency gains: A review of the literature*, Background paper prepared for the National Health and Hospitals Reform Commission.

230 S Duckett (2008), ‘The Australian health care system: reform, repair or replace?’, *Australian Health Review* 32(2): 322-329.

231 Business Council of Australia (2009), Submission 233 to the National Health and Hospitals Reform Commission: Second Round Submissions.

Furthermore, we believe that there is also a cost in not pursuing our recommendations – a cost in terms of the forgone improvements in health status and in equity of health outcomes, and of a less efficient, less responsive health care system, that is also less well prepared for the challenges of the future.

As the reform plan is further refined and put into action, we strongly urge that governments continue to consult with and involve health services, health professionals and the community more widely. There is an enthusiasm and readiness for change that, if constructively harnessed, can ensure Australians continue to enjoy one of the best health systems in the world.

APPENDICES



APPENDIX A: Terms of Reference

National Health and Hospitals Reform Commission

Terms of Reference

Australia's health system is in need of reform to meet a range of long-term challenges, including access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies generated by blame and cost shifting, and the escalating costs of new health technologies.

The Commonwealth Government will establish a National Health and Hospitals Reform Commission to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term, to address these challenges.

1. By April 2008, the Commission will provide advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care.
2. By December 2008, the Commission will provide an interim report on a long-term health reform plan to provide sustainable improvements in the performance of the health system.
3. By June 2009, the Commission will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to:
 - a. reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing;
 - b. better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;
 - c. bring a greater focus on prevention to the health system;
 - d. better integrate acute services and aged care services, and improve the transition between hospital and aged care;
 - e. improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;
 - f. improve the provision of health services in rural areas;
 - g. improve Indigenous health outcomes; and
 - h. provide a well qualified and sustainable health workforce into the future

The Commission's long-term health reform plan will maintain the principles of universality of Medicare and the Pharmaceutical Benefits Scheme, and public hospital care.

The Commission will report to the Commonwealth Minister for Health and Ageing, and, through her to the Prime Minister, and to the Council of Australian Governments and the Australian Health Ministers' Conference.

The Commonwealth, in consultation with the States and Territories from time to time, may provide additional terms of reference to the Commission.

The Commission will comprise a Chair, and a number of part-time commissioners who will represent a wide range of experience and perspectives, but will not be representatives of any individual stakeholder groups.

The Commission will consult widely with consumers, health professionals, hospital administrators, State and Territory governments and other interested stakeholders.

The Commission will address overlap and duplication including in regulation between the Commonwealth and States.

The Commission will provide the Commonwealth Minister for Health and Ageing with regular progress reports.

APPENDIX B: About the Commissioners



Dr Christine Bennett was in June 2008 appointed Chief Medical Officer of BUPA Australia Ltd, operating as MBF, HBA and Mutual Community. BUPA is a global health and care company with health insurance, aged care and wellness businesses and operates across 200 countries. At the time of her appointment as Chair of the Commission, Dr Bennett was Group Executive, Health and Financial Solutions, and Chief Medical Officer of MBF Ltd. Prior to that, Dr Bennett was Chief Executive Officer, Research Australia Ltd, a health and medical research advocacy organisation. Dr Bennett has worked in the health care industry as a clinician and chief executive in public, not-for-profit and private sectors, including as a Partner at KPMG, advising on health and life sciences transactions and business development.

Dr Bennett is a specialist paediatrician and a Fellow of the Royal Australasian College of Physicians. She was Head of Family and Child Health and then Director of Health Services Planning in NSW Health. She led major reforms of maternity and perinatal services in that state, negotiated the relocation of the Children's Hospital to Westmead, and implemented the NSW State Trauma Plan. She was subsequently the General Manager of the Royal Hospital for Women, relocating and building the new purpose-designed hospital on the Randwick campus, and then Chief Executive of Westmead Hospital and Community Health Services – arguably Australia's largest teaching hospital. She was subsequently Managing Director of a private health care company operating general practices, diagnostic services, a day surgery centre, and skin cancer clinics. Dr Bennett has served as a non-Executive Director for a number of publicly listed, private and charitable enterprises including Symbion Health care Ltd, Pacific Nursing Solutions Pty Ltd, and the Schizophrenia Research Institute, to name just a few. Throughout her career, Dr Bennett has been passionately committed to health and medical research and the medical profession's contribution to social issues, and served for two terms on the Council of the Royal Australasian College of Physicians.



Professor Justin Beilby is the Executive Dean, Faculty of Health Sciences, which oversees training for medical, dental, nursing, psychology and health sciences graduates at the University of Adelaide. Professor Beilby is also a Professor of General Practice at the University of Adelaide.

Professor Beilby has been in general practice in both rural and urban settings for over twenty years. He has been President of the Australian Association for Academic General Practice, and a member of the Strategic Research Initiative Working Group of the National Health and Medical Research Council (NHMRC). Professor Beilby has had a long career in general practice and primary care research, particularly in the areas of financing, chronic disease management, health services reform and quality initiatives.

He was Independent Chair of the Attendance Item Restructure Working Group which developed the seven-tier Medicare Benefits Schedule General Practice attendance item structure, and has been a member of the Australian Primary Health Care Research Institute Advisory Board.



Dr Stephen Duckett is President and Chief Executive Officer of Alberta Health Services, the organisation responsible for delivery of all public health services (hospitals, primary care, public health, emergency medical services) in the Canadian province of Alberta. With about 90,000 staff, it is the largest provider of health care in Canada. Prior to his current role, Dr Duckett was, from 2006 to 2009, Chief Executive of the Centre for Health care Improvement in Queensland Health, responsible for clinical governance, leadership transformation, health statistics and public reporting and improving hospital access (elective surgery, emergency department care, outpatients) across Queensland.

Dr Duckett was formerly (1996 to 2005) Professor of Health Policy and Dean of the Faculty of Health Sciences at La Trobe University – the Faculty is one of the largest providers of health professional education in Australia. He was convenor of the Council of Deans of Health Sciences from 1999 to 2005. Dr Duckett's research and publications focus on aspects of the Australian health care system (including health insurance, workforce), the economics of hospital care (particularly the use of casemix measures), and safety and quality of hospital care. He was awarded the degree of Doctor of Science by the University of New South Wales on the basis of his publications, and is also a Fellow of the Academy of the Social Sciences in Australia.

From 1994 to 1996, he was Secretary of the Commonwealth Department of Human Services and Health. From 1983 to 1993, he held various operational and policy positions in the Victorian Department of Health and Community Services and its predecessors, including Director of Acute Health Services, in which position he was responsible for designing and implementing Victoria's casemix funding policy. From 2000 to 2005, Dr Duckett chaired the boards of directors of Bayside Health (now Alfred Health) and the Brotherhood of St Laurence.

He is currently an Adjunct Professor at the University of Queensland (Australian Centre for Economics Research on Health and School of Population Health) and Griffith University (School of Public Health).



The Hon Dr Geoff Gallop AC is Professor, Director, Graduate School of Government, University of Sydney. Professor Gallop was the Premier of Western Australia from 2001 to 2006.

He was a Minister in the Lawrence Labor Government from 1990 to 1993 (holding a range of portfolios most notably Education, Fuel and Energy and Minister Assisting the Treasurer) and when that Government was defeated in 1993 he took up a range of Shadow Ministerial appointments. In 1994 he was elected Deputy Leader of the State Parliamentary Labor Party and in 1996 he was elected Leader.

As Premier, he oversaw a range of political and social reforms (electoral reform, gay and lesbian equality and a State Administrative Tribunal), upgraded the State's industrial and labour laws, brought a spirit of reconciliation to the resolution of Native Title and developed partnership models for the State's indigenous communities, changed the law to require all 16 and 17 year olds to be in education or training, was the first Premier to commit his government to a major desalination plant, stopped the logging of all of the State's Old Growth Forests creating record numbers of new national parks, restructured the State's electricity and racing industries, and started construction of the Perth to Mandurah Railway and City Tunnel.

As Minister for Science he established the Science Council, committed significant funding to Research and Development in the State, and established the Premier's Research Fellowship Program to attract leading researchers from overseas and interstate.

Dr Gallop has been involved in a range of educational, community and sporting associations over many years and from 1983 to 1986 he was a Councillor at the City of Fremantle.

In 2001 he was awarded a Commonwealth of Australia Centenary Medal and was honoured with Life Membership of the Association for the Blind (Western Australia).

In 2003 he was elected a Fellow of the Institute of Public Administration Australia and on the 4th April 2006 he was admitted to the Honorary degree of Doctor of Letters by Murdoch University.

In June 2008 Dr Gallop was honoured as a Companion of the Order of Australia (AC).



Dr Mukesh Haikerwal is a General Medical Practitioner in Melbourne's western suburbs, where he has practised since 1991.

He was the 19th Federal President of the Australian Medical Association (2005-2007), following two years as Federal Vice President and, prior to that, two years as Victorian State President.

He is currently working with the National e-Health Transition Authority (NEHTA) apprising the clinical health professional community of the benefits of the vital role of IT in health care.

Internationally, he is the Chair of the World Medical Association Finance and Planning Committee.

He was awarded Honorary Fellowships by both the Australian Medical Association (2005) and the Royal Australian College of General Practitioners (2007).

In June 2009, he was appointed as Professor in the School of Medicine in the Faculty of Health Sciences at Flinders University in Adelaide, South Australia.



Associate Professor Sabina Knight is a Remote Area Nurse and Associate Professor in Remote Health Practice and Remote Health Management at the Centre for Remote Health in Alice Springs.

Associate Professor Knight's professional activities have been focused on remote, isolated and rural health, in particular Aboriginal primary health care and health inequalities, and she is a recognised leader in remote health. Associate Professor Knight was a foundation member, and past president, of the Council of Remote Area Nurses of Australia (CRANA), foundation deputy Chair and Chair of the National Rural Health Alliance (NRHA) and Chair of the Central Australian Rural Practitioners Association (CARPA) editorial committee, producing the internationally recognised CARPA best practice guidelines for remote practitioners.

Associate Professor Knight has been awarded the Centenary Medal, the Louis Ariotti Award for excellence and leadership in rural health, and the CRANA Aurora Award for leadership and outstanding contribution to remote health. She holds a Master of Tropical Health, is a Fellow of the Australian Rural Leadership Foundation and the Royal College of Nursing Australia, a member of the Deputy Prime Minister's Regional Women's Advisory Council and the Northern Territory Health Minister's Advisory Council, and a Director of the Board of the Rural Health Education Foundation.



The Hon Rob Knowles AO is the Chairman of the Mental Health Council of Australia, President of the Mental Illness Fellowship of Australia, Chairman of the Campus Council of the Royal Children's Hospital Melbourne, Member of the Board of the Brotherhood of St Laurence, and Chair of the Committee of Management of the Joanna Briggs Institute Adelaide.

He is a Consultant and Adviser in the health sector and has a high level of expertise in public administration, having been a senior Minister in the Victorian Government for seven years, including Minister of Health.



Ms Mary Ann O'Loughlin is Executive Councillor and Head of the Secretariat of the COAG Reform Council. The Council's role is to monitor and assess progress in COAG's agenda for human capital, competition and regulatory reforms, as well as in the implementation of the new Commonwealth-State Financial Framework.

Before she joined the Council in 2008, Mary Ann had 20 years senior executive experience in both the public and corporate sectors. Formerly a Director of the Allen Consulting Group, a leading economics and public policy consulting firm, Mary Ann specialises in health and social policy analysis and development.

Mary Ann was Senior Adviser (Social Policy) to the then Prime Minister, the Hon Paul Keating, and held a number of senior positions in the Commonwealth Public Service, including Deputy Secretary of the Department of Employment, Education, Training and Youth Affairs, and First Assistant Secretary, Social Policy, Department of Prime Minister and Cabinet. Mary Ann has also worked as a senior executive for a major publicly listed health care company.



Professor Ronald Penny AO is one of Australia's leading immunologists and is currently Emeritus Professor of Medicine, University of NSW and Senior Clinical Advisor, NSW Department Health. In 1979, Professor Penny was awarded the first Doctor of Science for clinical research from the University of NSW, followed by a Personal Chair in clinical immunology in 1998.

Professor Penny has published over 360 medical and scientific papers in prestigious national and international journals.

He currently serves as Co-Chair of the Chronic Aged and Community Health Priority Task Force and is a member of the NSW Health Care Advisory Council, the NSW General Practice Council and the Physicians Taskforce. He was Chairman of the Justice Health Board from 1991–2007.

He is a Commissioner for the National Health and Hospitals Reform Commission and a Board Member for the National Centre for Indigenous Excellence.

He is also Medical Director of Good Health Solutions, a company dedicated to health promotion in the workplace, and Medical Director of Cryosite Pty Ltd.



Dr Sharon Willcox is the Director of Health Policy Solutions, an independent health consulting company. She has over 25 years experience working in health policy in government and the community sector.

Her government experience in the Victorian, New South Wales and Commonwealth health departments has included a leading role in the negotiations of the 1998–2003 and 2003–2008 Australian Health Care Agreements for funding public hospitals, improving public reporting on health system performance, and reforming the interface of acute and aged care services.

Dr Willcox was involved in the policy development for the National Health Strategy in the early 1990s on issues including new funding models for general practice. She also has a background in prevention and consumer advocacy through her work with the Cancer Council Victoria and the Health Issues Centre.

Dr Willcox has also worked in the United States on health policy and financing issues, as a Harkness Fellow in Health Care Policy in 1999–2000 and as a visiting scholar at the Center for Health Program Studies at Harvard University in 1992–93. Her Doctor of Public Health thesis examined the effectiveness of Australian private health insurance regulation.

APPENDIX C: Acknowledgements

Commission Secretariat

We would like to acknowledge the expertise, dedication and teamwork of our Secretariat staff. Our work over the past 16 months would not have been possible without the commitment of our Secretariat. This talented team has contributed significantly to all elements of our work including supporting consultations, policy development and research, media engagement, and the production of our reports. Whether with us for many months or just weeks, their contributions are greatly appreciated:

Joanna Holt, Executive Director (October 2008 – June 2009)
Lindy Hyam, Executive Director (April 2008 – August 2008)

John Flannery, Director, Media & Communications (April 2008 – July 2009)
Peter Broadhead, Director, Policy & Strategy (March 2008 – June 2009)

Ian Bigg, Policy Officer (February – June 2009)
Anne-Marie Boxall, Policy Officer (May – June 2009)
Dr Adrienne Hallam, Policy Officer (March – November 2008)
Emily Hurley, Policy Officer (April – June 2009)
Linda Jackson, Policy Officer (May 2008 – April 2009)
Ian McRae, Policy Officer (March – May 2009)
Janine Ramsay, Policy Officer (June 2008 – January 2009)
Liz Stackhouse, Policy Officer (May 2008 – June 2009)
Damien Tregear, Policy Officer (May 2008 – May 2009)

Chantal Aboud, Administrative Officer (May 2008 – April 2009)
Nancye Fleming, Administrative Officer (May 2008 – June 2009)
Maria Grassia, Administrative Officer (August – September 2008)
Ruth Hawkings, Administrative Officer (May 2008 – May 2009)
Michelle Nixon, Administrative Officer (June 2008 – July 2009)

Individuals and organisations

An enormous number of people and organisations contributed their passion and devoted time to conveying ideas, anecdotes and guidance to the Commission. Some were health policy experts who provided discussion papers; others provided learned analyses, position papers, or simply their heartfelt opinions. We are indebted to each and every one of you.

Friends, colleagues and family

Our work required us to spend many days and hours away from home and, when at home, our family and relaxation time was punctuated with phone calls, text messages and the constant companionship of email. Quality time with family and friends was a rare and treasured thing and, indeed, some of our number suffered personal and family tragedy, illness and injury over the period. Nevertheless, the ten of us who set off on this quest were still standing at the end. We could never have done it without the love and support of our families, friends and loved ones. Thank you to all of you.

APPENDIX D: Discussion Papers

- ***Estimates of the impact of selected NHHRC reforms on health care expenditure 2003–2033***, AIHW Canberra, June 2009
- ***Assessing the health service use of Aboriginal and Torres Strait Islander peoples***, John Deeble, June 2009
- ***The Australian health care system: the potential for efficiency gains***, June 2009
- ***Toward a roadmap for health system governance***, Mary Foley, 2009
- ***A new model for delivering selected mental health services in Australia***, Ian Hickie, 2008
- ***Costing a social insurance scheme for dental care***, Kirsten Armstrong and Mireille Campbell, November 2008
- ***Projection of Australian health care expenditure by disease***, John Goss, AIHW, December 2008
- ***E-Health: Enabler for Australia's Health Reform***, Booz & Company, November 2008
- ***Development of a Proposal for a National Roll-Out of Leading Edge Innovations on Prevention and Wellness***, Dr John Lang
- ***Distribution of Expenditure on Health Goods and Services by Australian Households***, Laurie Brown, Alicia Payne, Sharyn Lymer and Andrew Armstrong, NATSEM, University of Canberra, October 2008
- ***A national agency for promoting health and preventing illness***, Professor Rob Moodie, Todd Harper, Professor Brian Oldenburg, October 2008
- ***Achieving a patient-centred, effective, efficient, robust and sustainable primary and community care sector 2020***, Professor Claire Jackson and Adjunct Associate Professor Diana O'Halloran
- ***New models of primary and community care to meet the challenges of chronic disease prevention and management***, Mark Harris, Michael Kidd, and Teri Snowden
- ***Primary Care Reform Options***, Hal Swerissen
- ***New Models of Primary Care and Community Care with a Focus on Rural and Remote Care***, Associate Professor Isabelle Ellis, Debra Jones, Professor Sandra Dunn, and Dr Alison Murray
- ***Models of primary and community care in 2020***, Dr Beres Wenck and Ian Watts
- ***Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform***, Professor John Humphreys and Professor John Wakeman
- ***New and emerging nurse-led models of primary health care***, Professor Mary Chiarella
- ***Options for reform of Commonwealth and state governance responsibilities for the Australian health system***, Professor Judith Dwyer and Professor Kathy Eager
- ***A Mixed Public-Private System for 2020***, Mary Foley
- ***Funding Policy Options for Preventative Health Care within Australian Primary Health Care***, Professor Doris Young and Professor Jane Gunn
- ***A vision for primary care: Funding and other system factors for optimising the primary care contribution to the community's health***, Professor Leonie Segal
- ***A Preventative Priorities Advisory Committee and Prevention Benefits Schedule for Australia***, Associate Professor Anthony Harris
- ***Financial incentives, personal responsibility and prevention***, Professor Anthony Scott and Stefanie Schurer

APPENDIX E: Submissions in response to the NHHRC Interim report

Number	Name of Organisation or Individual
1	Margo Saunders
2	Eric Marshall
3	Individual Submission A
4	Kevin Griffey
5	Individual Submission B
6	Pam Hubbard
7	Christine Millsteed
8	Anthea Wynn
9	Jon Vance
10	David Brookman
11	Maurice White
12	Carol O'Donnell
13	Anne van Loon
14	Herman Lauwers
15	Australian College of Nurse Practitioners NSW
16	Christine Stolzenburg
17	Helen Blacklaws
18	Sue Denison
19	Michael Woolnough
20	James Lawson
21	Robert Falzon
22	Assoc Prof Jan Radford
23	Association for the Promotion of Oral Health
24	College of Nursing
25	Rennie Cacciola
26	University of Queensland (Blue Care)
27	Assoc Prof Kate Jackson
28	Professor Newell Johnson
29	Grant Thornton
30	Pain Management Australia
31	Kempsey Shire Council
32	Dr T Ahern
33	Dr Keith Beck
34	Edward Romano
35	Adults Surviving Child Abuse
36	Don Young
37	Australian Privacy Foundation
38	National Seniors Australia
39	Microsoft Australia
40	Barbara McGarity
41	Dr Michael Neaverson
42	Dr Lisa New
43	Betty Johnson
44	Australian Self Medication Industry
45	Professors of Psychiatry Unis of Melb & Monash
46	Arthritis NSW
47	Drs Clive Heath & Craig Turner

48	Andrew Francis
49	Individual Submission C
50	Dental Health Services Victoria
51	Rick O'Brien
52	Australian Dental Association Queensland
53	Dr Ronald Wells
54	Aged Care Association Australia
55	MH & ED Lotton
56	Queensland Nurses Union
57	Dr Pauline Watter et al
58	Pacific Strategy Partners
59	David Karr
60	Queensland Aboriginal and Islander Health Council
61	GP Access
62	Schizophrenia Research Institute
63	Ian Smith
64	Australian Primary Care & Community Partnership
65	Mental Health Coordinating Council
66	National Rural Health Alliance
67	Ian Larmour
68	Congress of Aboriginal and Torres Strait Islander Nurses
69	Municipal Association of Victoria
70	COTA NSW
71	Darebin Community Health
72	General Practice Gold Coast
73	ECH Resthaven & Eldercare
74	Genevieve Beggs
75	HMHFRG Murdoch Children's Research Institute
76	Australian Private Hospitals Association
77	Consumers' Health Forum of Australia
78	Royal Australian and New Zealand College of Psychiatrists
79	Sophie Hill & Mary Draper
80	Carers NSW
81	Jason Maher
82	Walwa Bush Nursing Centre
83	Ben Mullings
84	Stanislaw Wargin
85	Dr Clive Jones
86	Dr Ken Piaggio
87	Anthony Engel
88	Services For Australian Rural and Remote Allied Health
89	Audrey Robb
90	Dr John Myers
91	Doctors Reform Society
92	Rural Dental Action Group
93	Medication Services Queensland (Queensland Health)
94	National Oral Health Promotion Steering Group
95	Dr Katie Thomas
96	Greater Southern Area Health Service NSW
97	Sutherland Division of General Practice
98	Alzheimer's Australia
99	Professor Allan Carmichael
100	Silver Chain
101	Council of Deans of Nursing and Midwifery

102	Royal College of Nursing Australia
103	Australian Commission on Safety and Quality in Health Care
104	Australasian Podiatry Council
105	Need More GPs
106	Australian and New Zealand society of Palliative Medicine
107	Palliative Care Australia
108	Rural Health Workforce Australia
109	Indigenous Dentists Association of Australia
110	General Practice Queensland
111	Australian Unity
112	Royal Australian College of General Practitioners
113	GP Partners
114	Peter MacCallum Cancer Centre
115	Health Services Research Association Australia and New Zealand
116	Local Government Shires Association
117	Australian Health Service Alliance
118	The George Institute
119	City of Darebin
120	Close the Gap Steering Committee
121	Brisbane South Division of General Practice
122	Bio21 Cluster
123	Brimbank City Council
124	Citizens Committee on Human Rights
125	HealthWest
126	Dietitians Association of Australia
127	Royal Australasian College of Physicians
128	Northern Sydney General Practice Network
129	Australian Association of Social Workers
130	Professor Paul Mullen et al
131	Down Syndrome Victoria
132	Private Mental Health Consumer Carer Network
133	Australian Nursing Federation
134	Australian Council of Social Services
135	Women's and Children's Hospitals Australasia
136	Carers Australia
137	Victorian Health care Association
138	NSW Consumer Advisory Group – Mental Health Inc
139	Australian College of Midwives
140	Professor David Penington et al
141	Australian Rural Health Education Network
142	General Practice South Australia – Mental Health Issues
143	Australian General Practice Network
144	Brotherhood of St Laurence
145	Optometrists Association Australia
146	Professors John Wakerman & John Humphreys
147	Latrobe Community Health Service
148	General Practice Victoria
149	GlaxoSmithKline
150	AMSANT
151	Motor Neurone Disease Australia
152	Assoc Prof Joachim Sturmberg
153	COTA Over 50s
154	National Coalition of Public Pathology
155	General Practice South Australia

156	Australian College of Ambulance Professionals
157	Roger Hewitt
158	Dr Paul Wood
159	Jenny Corran
160	GP Links Widebay
161	Medical Deans Australia and New Zealand
162	Vision 2020 Australia
163	Australian Orthotic and Prosthetic Association
164	Professor David Penington AC
165	NSW Mental Health Priority Taskforce
166	Health Information Management Association of Australia
167	Australian Physiotherapy Association
168	Speech Pathology Australia
169	Health Insurance Restricted and Regional Membership Association of Australia
170	Australian and New Zealand College of Anaesthetists
171	Dr David More
172	Australian Health Workforce Institute
173	National Heart Foundation and National Stroke Foundation
174	Royal District Nursing Service South Australia
175	Wyeth Australia
176	Medical Technology Association of Australia
177	Psychology Private Australia Inc
178	Australian Medical Council
179	Australian Society of Plastic Surgeons
180	Pharmaceutical Society of Australia
181	National Herbalists Association of Australia
182	Women's Health West
183	Faculty of Medicine, Dentistry & Health Sciences, University of Melbourne
184	Menzies School of Health Research
185	Mercy Aged Care Services
186	Medilink Australia
187	Royal College of Pathologists of Australasia
188	Dr Jeremy Rourke
189	Prof John Spencer & Jane Harford
190	Catholic Health Australia
191	CHOICE
192	Cancer Council Australia & Clinical Oncology Society of Australia
193	Royal District Nursing Service
194	Southern General Practice Network
195	Dr Sophie Bibrowska et al
196	Australian Nursing and Midwifery Council
197	The Sax Institute
198	DHS Victoria Cancer & Palliative Care Unit
199	Menzies Centre for Health Policy
200	Port Phillip Council Older Persons Consultative Committee
201	Neville Crew OAM
202	Sophie Dyson et al
203	Australasian College of Podiatric Surgeons
204	Pharmacy Guild of Australia
205	Professor Hal Kendig
206	Health Care Consumers Association
207	James Lithgow
208	University of Queensland
209	Danny Stewart

210	Geoff Isaac
211	Toni Falk
212	Australian Faith Community Nurses Association Inc
213	Australian Health Insurance Association
214	Heather Sleeman
215	Dr Robert Corrie
216	Research Australia
217	Australian College of Rural and Remote Medicine
218	GMHBA Health Insurance
219	Australian Federation of AIDS Organisations
220	Australian Dental Association
221	Medibank Private
222	Australian Health care & Hospitals Association
223	Professor Just Stoelwinder et al
224	NSW Council for Intellectual Disability
225	Associate Professor Roger Gurr
226	Universities Australia
227	Australian Medical Association
228	Australian College of Private Consulting Psychologists NSW
229	Dr Terry Thomas
230	Sydney West Area Health Service
231	SA Health
232	Mental Illness Fellowship of Australia
233	Business Council of Australia
234	NSW Health
235	Cabrini Health
236	UQ Centre for Online Health
237	Bupa Australia
238	Health Consumers Alliance of South Australia
239	Kempsey & District Ratepayers & Residents Association
240	Public Health Association of Australia
241	CSIRO
242	Tasmanian Government
243	Commission for Children and Young People
244	Confederation of Postgraduate Medical Education Councils
245	Australian Medical Students Association
246	Royal Australasian College of Surgeons
247	Victorian Refugee Health Network
248	Australian College of Health Service Executives Victoria
249	Group of Eight
250	Helen Owens
251	Australian Psychological Society
252	Dr Bruce Simmons
253	A Prof James Bennett-Levy
254	Allied Health Professions Australia
255	Association of Australian Medical Research Institutes
256	Health Consumers' Council Western Australia
257	GP partners Adelaide
258	Anne Cahill Lambert AM
259	Australian College of Nurse Practitioners
260	Grace Coyle
261	Anne Monten
262	Ballarat Trades Hall
263	Evelyn Doyle

264	Dr Pat Jackman
265	Dr Gary Rutledge
266	Roger Simpson
267	Aged and Community Care Victoria
268	Australian Society of Anaesthetists
269	Nimbin Neighbourhood and Information Centre
270	Australian Dental and Oral Therapists' Association
271	Royal Australian and New Zealand College of Ophthalmologists
272	Dr Ruth Arnold
273	Aged Care Round Table Participants
274	Western Australian Government
275	Peter Walpole
276	Australian Association of Consultant Physicians
277	Australian General Practice Network Supplementary Submission
278	Katherine McGrath et al
279	National Federation of Parents, Families and Carers
280	Victorian Government
281	Advance Directive Special Interest Group
282	Council of Ambulance Authorities
283	UnitingCare Australia
284	Susanna Scurry
285	National Health and Medical Research Council
286	Maribyrnong City Council
287	Peter Butters
288	Tasmanian Infection Control Association
289	Carol O'Donnell
290	Medibank Private
291	Australian Commission on Safety and Quality in Health Care
292	Dr Kathy Dynes
293	Dr Jerome Mellor
294	Andrew Podger
295	Chief Health Professions Office, WA Health.
296	Jon Patrick
297	Dr Kathryn Antioch
301	National and NSW Councils for Intellectual Disability and for the Australian Association of Developmental Disability Medicine
302	Dr Tony Sara
303	John Zubevich
304	Bain Family
305	Australian Privacy Foundation
306	Macquarie Health Corporation
307	Australian Medical Association
308	Consumers Health Forum of Australia
309	Dr David G Moore
310	National Health Call Centre Network
311	Brendon Wickham
312	Dietitians Association of Australia
313	Microsoft
314	Pharmaceutical Society of Australia
315	Australian General Practice Network
316	Office of the Privacy Commissioner
317	Cancer Voices Australia

APPENDIX F: Design and governance principles

We developed a set of principles to guide reform and future directions of the Australian health system.

These principles should, to a large extent, shape the whole health and aged care system – public and private, and hospital and community-based services.

Design principles

(generally what we as citizens and potential patients want from the system).

1. **People- and family-centred.** The direction of our health and aged care system, the provision of health and aged care services and our efforts to strengthen wellness and prevention must be shaped around the health needs of people, their families, carers and communities. A people focus reflects not only responsiveness to individual differences, abilities and preferences, but is grounded in the social and community context of people's lives and their ability to exercise choice. This recognises the need to be responsive to factors such as cultural diversity (including Indigenous cultural traditions), people's 'lived experience' of illness and disability, and the broader social, educational and environmental settings that frame their lives and communities. Pathways of care, currently often complex and confusing, should be easy to navigate. People should be given help, where necessary, to navigate the system including through reliable and evidence-based information and advice to help them make appropriate choices, in association with their families, carers and advocates. Care should be provided in the most favourable environment: closer to home if possible, with a preference for less 'institutional' settings, recognising the need to support the important role of families and carers, and with an emphasis on supporting people to achieve their maximum health potential.
2. **Equity.** Health and aged care services in Australia should be accessible to all based on health needs, not ability to pay. The multiple dimensions of inequity and disadvantage should be addressed, whether related to Indigenous status, geographic location, socio-economic status, disability, gender, language or culture. A key underpinning for equity is the principle of universality as expressed in the design of Medicare, the Pharmaceutical Benefits Scheme, public hospital care and residential and community aged care services. Recognising, however, that universal entitlements do not always translate to the achievement of either universal access or equitable outcomes, a focus on equity also requires a commitment to tackling disadvantage through targeting services to those most in need to improve health outcomes. Addressing inequity in health and aged care access and outcomes also requires action beyond universal programs, including through engagement with other policy sectors (such as the education system, and employment) and a focus on the social determinants of health. The health and aged care system must recognise and respond to those with special needs (the marginalised or under-provided for groups in society). Special attention needs to be given to working with Aboriginal and Torres Strait Islander people to close the gap between Indigenous health status and that of other Australians.
3. **Shared responsibility.** All Australians share responsibility for our health and the success of the health and aged care system. Within the context of our physical and social circumstances, life opportunities and the broad economic and cultural environment, we make decisions about our life-style and personal risk behaviours which impact our health risks and outcomes. As a community we fund the health and aged care system. As consumers or patients we make decisions, often with the support of our families, carers and advocates, about how we will use the health and aged care system and work with the professionals who care for us. Health and aged care professionals have a responsibility to communicate clearly, to help us understand the choices available to us, and to support us to take an active role in our health and treatment in a relationship of mutual respect. This extends beyond responsibility for improving individual health outcomes to contributing to healthy public policy and supporting environments that increase everyone's opportunities to achieve their potential in health and wellbeing.

The health and aged care system can only work effectively if everyone participates to the best of their ability and circumstances, according to these shared responsibilities, recognising and valuing the important roles of consumers/patients, their families and carers, advocates and community groups and staff. The health system has a particularly important role in helping people of all ages and abilities become more self reliant, health literate and better able to manage their own health care needs. This includes helping people to make informed decisions through access to health information that supports informed consent and participation; by providing support and opportunities to make healthy choices; and by providing assistance for managing complex health needs.

4. **Promoting wellness and strengthening prevention.** We need a comprehensive and holistic approach to how we organise and fund our health and aged care services and work towards improving the health status of all Australians. The balance of our health system needs to be reoriented. Our health system must continue to provide access to appropriate acute and emergency services to meet the needs of people when they are sick. Balancing this fundamental purpose, our health system also needs greater emphasis on helping people stay healthy through stronger investment in wellness, prevention and early detection and appropriate intervention to maintain people in as optimal health as possible. This focus on prevention and improving health and wellbeing should apply across the life course and irrespective of health status.

Recognising the diverse influences on health status, our health and aged care system should create broad partnerships and opportunities for action by the government, non-government and private sectors; balance the vital role of diagnosis and treatment with action and incentives to maintain wellness; create supportive environments and policies to improve health functioning for people with long-term needs including those with a chronic condition or disability; and protect our health and prevent disease and injury in order to maximise each individual's health potential.

5. **Comprehensiveness.** The health and aged care system should be able to meet the entire range of people's health needs over their life course. Meeting those needs requires a system to be built on a foundation of strong primary health care services with timely access to all other health and aged care services organised to promote continuity of care and good communication across the various health and aged care professionals. Comprehensiveness requires a balance between the vital role of diagnosis and treatment with action and incentives to maintain wellness. A life course approach to improving health and wellness includes a strong emphasis on a healthy start to life, support for the whole spectrum of health needs during life including physical, mental and psychosocial, and appropriate care and support at the end of life. A comprehensive health and aged care system ensures that care is available in a range of settings, with a focus on care in communities close to people and their families, so that caring, living with illness or disability, ageing and dying can all be 'in place'.
6. **Value for money.** The resources available to support our health and aged care system are finite, and the system must be run as efficiently as possible and be positioned to respond to future challenges. Delivering value for money will require appropriate local flexibility in financing, staffing and infrastructure. The health and aged care system should deliver appropriate, timely and effective care in line with the best available evidence, aiming at the highest possible quality. Information relating to the best available health evidence should be easily available to professionals and patients to make value-conscious choices. Health promotion programs must also be underpinned by a sound evidence base. Introduction of new technology should be driven by evidence and cost-effectiveness. Pathways to care should be seamless with continuity of care maximised, with systems in place to ensure a smooth transfer of information at each step of the care pathway, making effective use of information technology.

7. **Providing for future generations.** We live in a dynamic environment: health needs are changing with improved life expectancy, community expectations rising, advances in health technologies, an exploding information revolution and developments in clinical practice. There are new avenues and opportunities for how we organise and provide necessary health and aged care to individuals, using the health and aged care workforce and technologies in innovative and flexible ways. The education and training of health and aged care professionals across the education continuum are a responsibility of the whole health and aged care community in partnership with the education sector. The important responsibility of the health care system in teaching, training future generations of health professionals for a changing health care sector and roles, participating in research and in creating new knowledge for use in Australia and throughout the world should be actively acknowledged and resourced appropriately as an integral activity.
8. **Recognising that broader social and environmental influences shape our health.** Our environment plays an important role in affecting our health and in helping us to make decisions that promote our health. The environment here is taken to mean the global climate, the physical and built environment (factors such as air quality, the workplace, urban planning decisions which affect our health and access to good housing) and the socio-economic environment (people in the workforce generally have better health than the unemployed, better educated people have better health and have responded better to health campaigns and tend to smoke less). Our families, workplaces and schools shape both our health (and the development of our children) and our adoption of healthy lifestyles. The health system of the future needs to work at these multiple levels to promote health and wellbeing with many and varying agencies and partnerships. These partnerships must be effective and also involve players outside the health system, whether they are transport departments, local councils, employers, business and worker organisations, and schools and universities. Strong, connected and inclusive communities help support people and families in their efforts to make decisions that promote their health and wellbeing.

Governance principles

(generally how the health system should work)

9. **Taking the long-term view.** A critical function for effective governance of the health and aged care system is that it acts strategically: that short-termism and the pressure of the acute do not crowd out attention and planning for the long term. A responsible forward-looking approach demands that we actively monitor and plan the health and aged care system of the future to respond to changing demographics and health needs, clinical practices and societal influences. This requires capacity to seek input from the community and those within the health and aged care sectors (providers and managers), to assess evidence and develop and implement plans to improve health and aged care.
10. **Quality and safety.** There should be effective systems of clinical governance at all levels of the health and aged care system, to ensure continuous improvement in the quality and safety of services. Effective clinical governance makes certain that there is accountability and creates a 'just' culture that is able to embrace open, transparent reporting and support improvement. Patients, together with their families, carers and advocates, are central to identifying quality and safety issues (including the patient experience dimension of quality) and the solutions that need to be implemented. This requires a partnership approach between consumers and health and aged care professionals, supported by good information and clear acknowledgement of the rights of consumers to be actively involved in their care. All of this requires the development of effective organisational systems that promote quality and safety, including appropriate systems of open disclosure and public accountability for the whole system. Quality extends beyond the use of systems to reduce and manage adverse events and errors to promoting a culture of excellence and continuous improvement across the entire health and aged care system.
11. **Transparency and accountability.** The decisions governments, other funders and providers make in managing our health and aged care system should become clearer and more transparent. Funding should be transparent. The responsibilities of the Commonwealth and state governments and the private and non-government sectors should all be clearly delineated so that, when expectations are not met, it is clear where accountability falls. Accountability

extends to individual health and aged care services and professionals. Implementation of greater accountability should occur in such a way that it is supported and trusted by all parties. Australians are entitled to regular reports on the status, quality and performance of our whole health and aged care system, both public and private, ranging across the spectrum from primary to tertiary care and at local, state and national levels. This includes monitoring, evaluation and reporting to the community on the implementation and effectiveness of plans, policies and strategies that are designed to improve health outcomes for the Australian community.

12. **Public voice and community engagement.** Public participation is important to ensuring a viable, responsive and effective health and aged care system. This recognises and values the importance of a person's experience of the health and aged care system and in living with their health condition. Participation can and should occur at multiple levels, reflecting the different roles that individuals play at different times in their lives. This includes participation as a 'patient' or family member in using health and aged care services, participation as a citizen and community member in shaping decisions about the organisation of health and aged care services and participation as a taxpayer, voter, and in some cases shareholder, in holding governments and corporations accountable for improving the health and aged care system. Effective participation also recognises the valuable role of advocacy and self-help groups, non-government organisations and other communities of interest that contribute to improving the performance and responsiveness of the health and aged care system. Participation also involves engaging the whole community in priority setting and decision-making about what can be reasonably and equitably provided in the health and aged care system.
13. **A respectful, ethical system.** Our health and aged care system must apply the highest ethical standards, and must recognise the worth and dignity of the whole person including their biological, emotional, physical, psychological, cultural, social and spiritual needs. The humanity of care is integral, based upon the highly personal nature of health and aged care and the importance of trust and partnerships between patients, families, carers and health and aged care professionals. Care should be provided in a manner that does not support discrimination against any individual or group and, indeed, is organised to positively foster access and improved health outcomes for the most disadvantaged and marginalised in our society. A significant focus must include respect and valuing of health and aged care workers by patients, families, carers and the community. Our health and aged care workers are a precious resource that should be valued. Those working within the health and aged care sectors must be aware of ethical considerations throughout their training and in their daily clinical practice.
14. **Responsible spending.** Good management should ensure that resources flow effectively to the front line of care, with accountability requirements efficiently implemented and red tape minimised. Wastage and duplication of services should be avoided including through improving communication and connectivity with better sharing of information across those involved in providing care. Funding mechanisms should reward best practice models of care, rather than models of care being inappropriately driven by funding mechanisms. Funding systems should be designed to promote continuity of care with common eligibility and access requirements to avoid program silos or 'cracks' in the health system. There should be a balanced and effective use of both public and private resources. New technologies should be evaluated in a timely manner and, where shown to be cost effective, should be implemented promptly and equitably. Information and communication technologies, in particular, should be harnessed to improve access in rural and remote areas on a cost effective basis, to support and extend the capacity of all health professionals to provide high quality care.
15. **A culture of reflective improvement and innovation.** Reform, improvement, and innovation are continuous processes and not fixed-term activities. The Australian health and aged care system should foster innovation, research and sharing of practices shown to be effective and to improve not only the specific services it provides, but also the health of all Australians. Robust data and a sophisticated approach to knowledge management, including its generation, dissemination and application, are also critical. The continuum of basic science to clinical and health services research will underpin this and needs to be embedded.

APPENDIX G: Implementing reforms

This appendix provides a preliminary and indicative action plan for implementing our recommendations. The table presents all final recommendations (with a reference in brackets to the originating reform direction from our Interim Report), under the chapter headings from our Interim Report. This table provides comment on some key aspects of implementation, notes whether recommendations would form part of the Healthy Australia Accord, and suggests the lead responsibility and key groups who should action the recommendation. Undoubtedly, as more detailed planning and development work is undertaken, there will be sound reasons to vary some of what is set out here.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
1. Building good health and wellbeing into our communities and our lives				
1. We affirm the value of universal entitlement to medical, pharmaceutical and public hospital services under Medicare which, together with choice and access through private health insurance, provides a robust framework for the Australian health care system. To promote greater equity, universal entitlement needs to be overlaid with targeting of health services to ensure that disadvantaged groups have the best opportunity for improved health outcomes. (RD 1.1)				
2. Australian governments and the Australian community should acknowledge that the scope of the universal entitlement and service obligation funded by public monies will need to be debated over time to ensure that it is realistic, affordable, fair and will deliver the best health outcomes while reflecting the values and priorities of the community. Mechanisms for effectively conducting this dialogue should be developed and should include expert clinical, economic and consumer perspectives. (New)			Commonwealth Government	
3. Listening to the views of all Australians about our health system and health reform is essential to the ongoing sustainability and responsiveness of our health system. Accordingly, we recommend regular monitoring and public reporting of community confidence in the health system and the satisfaction of our health workforce. (New)			Commonwealth Government	
4. We recommend that public reporting on health status, health service use, and health outcomes by governments, private health insurers and individual health service providers identifies the impact on population groups who are likely to be disadvantaged in our communities. (RD 1.2)	Requires commitment to development within a timeframe and identification of responsible body to undertake development and prepare regular reports. We suggest it be the AIHW.	HAA	Commonwealth Government	Australian Institute of Health and Welfare (AIHW) working with state governments, insurers, and health service providers.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
5. We recommend the preparation of a regular report that tracks our progress as a nation in tackling health inequity. (RD 1.3)		HAA	Commonwealth Government	Commonwealth Government through AIHW.
6. We recommend the development of accessible information on the health of local communities. This information should take a broad view of the factors contributing to healthy communities, including the 'wellness footprint' of communities and issues such as urban planning, public transport, community connectedness, and a sustainable environment. (RD 1.4)	This is already established in Victoria: http://www.communityindicators.net.au/ .		Commonwealth Government	National Health Promotion and Prevention Agency (NHPPA).
7. We support the delivery of wellness and health promotion programs by employers and private health insurers. Any existing regulatory barriers to increasing the uptake of such programs should be reviewed. (RD 1.5)	Requires review by governments working with employers and private insurers to identify regulatory barriers. Legislative changes may be required	HAA	All governments	Relevant government agencies.
8. We recommend that governments commit to establishing a rolling series of ten-year goals for health promotion and prevention, to be known as Healthy Australia Goals, commencing with Healthy Australia 2020 Goals. The goals should be developed to ensure broad community ownership and commitment, with regular reporting by the National Health Promotion and Prevention Agency on progress towards achieving better health outcomes under the ten-year goals. (RD 1.6)	Process to determine goals over first year, including broad community input. Establishment of community grants for development of local initiatives to reach goals. Reporting of activity and monitoring of progress second yearly against goals.	HAA	Commonwealth Government through COAG.	NHPPA
9. We recommend the establishment of an independent national health promotion and prevention agency. This agency would be responsible for national leadership on the Healthy Australia 2020 goals, as well as building the evidence base, capacity and infrastructure that is required so that prevention becomes the platform of healthy communities and is integrated into all aspects of our health care system. (RD 1.7)	To draw upon experience of similar state initiatives such as VicHealth and HealthWay (WA), to sponsor cost effectiveness research and assessment of prevention initiatives.	HAA	Commonwealth Government through COAG.	Commonwealth Government

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
We recommend that the national health promotion and prevention agency would also collate and disseminate information about the efficacy and cost effectiveness of health promotion including primary, secondary and tertiary prevention interventions and relevant population and public health activities. (RD 1.8)			National Health Promotion and Prevention Agency	Agency with input from independent researchers.
10. We support strategies that help people take greater personal responsibility for improving their health through policies that 'make healthy choices easy choices'. This includes individual and collective action to improve health by people, families, communities, health professionals, health insurers, employers and governments. Further investigation and development of such strategies should form part of NHPPA work on the Healthy Australia 2020 Goals targeting cross portfolio and cross industry action. (RD 1.9)			Commonwealth Government	Department of Prime Minister and Cabinet
11. We recommend that health literacy is included as a core element of the National Curriculum and that it is incorporated in national skills assessment. This should apply across primary and secondary schools. (RD 1.10)			Commonwealth Government – states and territories through National Curriculum Board.	National Curriculum Board
12. We urge all relevant groups (including health services, health professionals, non-government organisations, media, private health insurers, food manufacturers and retailers, employers and governments) to provide access to evidence-based, consumer-friendly information that supports people in making healthy choices and in better understanding and making decisions about their use of health services. (RD 1.11)			All governments to consider how to provide incentives for this.	
13. To support people's decision making and management of their own health we recommend that, by 2012 every Australian should be able to have a personal electronic health record that will at all times be owned and controlled by that person. (RD 16.1)				

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
14. We acknowledge the vital role of informal/family carers in supporting and caring for people with chronic conditions, mental disorders, disabilities and frailty. We recommend that carers be supported through educational programs, information, mentoring, timely advice and, subject to the consent of those they care for, suitable engagement in health decisions and communications. We also recommend improved access to respite care arrangements to assist carers sustain their role over time and that the health of carers should also be a priority of primary health care services dealing with people with chronic conditions. (New)				
15. We recognise that the health of individuals and the community as a whole is determined by many factors beyond health care, such as a person's social circumstances and the physical environment in which they live; how they live their lives – their behaviours and lifestyles; and their biological and genetic predispositions. We commend the World Health Organisation's call for action by national governments to address the social determinants of health. (New)			Commonwealth Government	
2. Creating strong primary health care services for everyone				
16. We recommend that, to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding. (RD 2.1)	Proposed approach would see Commonwealth Government reducing general purpose grants to states (GST revenue) by the amount each state currently commits to these services, and then for the first 3 years providing these funds back to the states and territories to continue service provision while arrangements are developed for the Commonwealth Government to take direct responsibility for policy and funding of comprehensive primary health care after that initial 3 year period.	HAA	Commonwealth Government through COAG	Commonwealth Government working with states and territories and in consultation with bodies representing primary health care services.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
17. We recommend that, in its expanded role, the Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres and Services. We suggest this could be achieved through a range of mechanisms including initial fixed establishment grants on a competitive and targeted basis. By 2015 we should have a comprehensive primary health care system that is underpinned by a national policy and funding framework with services evolving in parallel. (RD 2.2)	Capital/establishment grants as incentives to develop centres/services. Requires development of standards for recognition of Comprehensive Primary Health Care Centres or Services, with payment of one-off grant for achievement of Centre or Service.	HAA	Commonwealth Government through COAG	Commonwealth Department of Health and Ageing (DoHA) working with state and territory health departments and in consultation with representatives of health professions and relevant organisations, including Primary Health Care Organisations (see recommendation 21).
18. We recommend that young families, Aboriginal and Torres Islander people and people with chronic and complex conditions (including people with a disability or a long-term mental illness) have the option of enrolling with a single primary health care service to strengthen the continuity, co-ordination and range of multidisciplinary care available to meet their health needs and deliver optimal outcomes. This would be the enrolled family or patient's principal "health care home". To support this, we propose that:			Commonwealth Government	
<ul style="list-style-type: none"> there will be grant funding to support multidisciplinary services and care coordination for that service tied to levels of enrolment of young families and people with chronic and complex conditions; 	<ul style="list-style-type: none"> Definition of characteristics of people who count towards enrolment for the purposes of payment of grants; Designation/recognition of services eligible for grants for enrollees; Establishment of payments to services per enrollee. Legislative changes required		Commonwealth Government	DoHA in consultation with representatives of health professions and relevant organisations, and working with state and territory departments in respect of state primary health care services in first 3 years.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<ul style="list-style-type: none"> there will be payments to reward good performance in outcomes including quality and timeliness of care for the enrolled population and over the longer term, payments will be developed that bundle the cost of packages of primary health care over a course of care or period of time, supplementing fee-based payments for episodic care. (RD 2.3) 	<p>Need to progressively define and implement measures of quality and timeliness.</p> <p>Measures to be developed in consultation with clinical experts.</p> <p>Timeliness to be developed as part of National Access Targets (see recommendation 27 below)</p>		Commonwealth Government	<p>Australian Commission on Safety and Quality in Health Care (ACSQHC) to develop measures;</p> <p>DoHA to develop payments policy.</p>
<ul style="list-style-type: none"> over the longer term, payments will be developed that bundle the cost of packages of primary health care over a course of care or period of time, supplementing fee-based payments for episodic care. (RD 2.3) 	<p>Development to commence with health services research into effective patterns of care across unified primary health care once consolidation of responsibility under the Commonwealth has had time to stabilise.</p> <p>Legislative changes required</p>		Commonwealth Government	DoHA in consultation with key provider groups and consumer representatives, also informed by health services research.
19. We recommend embedding a strong focus on quality and health outcomes across all primary health care services. This requires the development of sound patient outcomes data for primary health care. We also want to see the development of performance payments for prevention, timeliness and quality care. (RD 2.4)	<p>Development work on measures of patient outcome will require consultation with consumer representatives and clinicians.</p> <p>Approaches to performance payment to be developed as part of recommendation 18 above.</p>		Commonwealth Government	DoHA with ACSQHC in consultation with key provider groups and consumer representatives.
20. We recommend improving the way in which general practitioners, primary health care professionals and medical and other specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting. These arrangements should promote good communications and the vital role of primary health care professionals in the ongoing management and support of people with chronic and complex conditions in partnership with specialist medical consultants and teams who provide assessment, complex care planning and advice. (RD 2.5)	<p>Collaborative work between Royal Australian College of General Practice, Royal College of Nursing and Midwifery, specialist medical colleges and relevant bodies for allied health disciplines to delineate evidence based models of shared care for people with chronic conditions or protracted acute conditions (e.g. recovery from stroke or trauma, or treatment of cancer).</p>		Commonwealth Government with involvement of ACSQHC and National Institute of Clinical Studies (NICS) and relevant health professional groups.	Relevant health professional groups and consumer representatives to collaborate in development of models of best practice in multi-disciplinary care across generalist and specialist disciplines.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
20. (continued)		<p>Develop models of best practice in multi-disciplinary care across generalist and specialist disciplines.</p> <p>Capacity to participate in such approaches to be an aspect of recognising comprehensive primary health care services, and of the provision of public hospital specialist clinics whether hospital or community based (see 31 below).</p>		
21. Service coordination and population health planning priorities should be enhanced at the local level through the establishment of Primary Health Care Organisations, evolving from or replacing the existing Divisions of General Practice. These organisations will need to:	<ul style="list-style-type: none">• have appropriate governance to reflect the diversity of clinicians and services forming comprehensive primary health care;• be of an appropriate size to provide efficient and effective coordination (say approx 250,000 to 500,000 population depending on health need, geography and natural catchments); and• meet required criteria and goals to receive ongoing Commonwealth funding support. (RD 2.6)	<p>While work should commence in 2009–10, the development of these should parallel the Commonwealth acquiring a better understanding of the non-GP primary health care sector. Hence it is proposed that there be initial funding over 3 years for GP Divisions to change their governance and membership to incorporate non-medical primary health care providers working in government services and in private practice within their region, and to redevelop their strategic and operational plans to address local priorities within 2 years. The Australian General Practice Network should also be funded to redevelop as the Australian Primary Health Care Network, with broad representation on its governing body from non-medical primary health care providers from both private practice and government services.</p>	Commonwealth Government	DOHA working with Australian General Practice Network (AGPN).

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>3. Nurturing a healthy start to life</p> <p>22. We recommend an integrated strategy for the health system to nurture a healthy start to life for Australian children. The strategy has a focus on health promotion and prevention, early detection and intervention and management of risk, better access to primary health care, and better access to and coordination of health and other services for children with chronic or severe health or developmental concerns.</p> <p>We recommend a strategy for a healthy start based on three building blocks:</p> <ul style="list-style-type: none"> • most importantly, a partnership with parents, supporting families – and extended families – in enhancing children’s health and wellbeing; • a life course approach to understanding health needs at different stages of life, beginning with pre-conception, and covering the antenatal and early childhood period up to eight years of age. While the research shows that the first three years of life are particularly important for early development, we also note the importance of the period of the transition to primary school; and • a child- and family-centred approach to shape the provision of health services around the health needs of children and their families. Under a ‘progressive universalism’ approach, there would be three levels of care: universal, targeted and intensive care. (RD 3.1 & 3.2) 	<p>Work on this should be undertaken as part of policy development for primary health care services.</p> <p>Integrate with early childhood agenda across portfolios.</p>		Commonwealth Government	DoHA working with state and territory governments in consultation with relevant portfolios, health professional groups and child health services.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>23. We recommend beginning the strategy for nurturing a healthy start to life before conception. Universal services would focus on effective health promotion to encourage good nutrition and healthy lifestyles, and on sexual and reproductive health services for young people. Targeted services would include ways to help teenage girls at risk of pregnancy. In the antenatal period, in addition to good universal primary health care, we recommend targeted care for women with special needs or at risk, such as home visits for very young, firsttime mothers. (RD 3.3 & 3.4)</p> <p>24. We recommend that universal child and family health services provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring (with contacts weighted towards the first three years of life).</p> <ul style="list-style-type: none"> • The initial contact would be universally offered as a home visit within the first two weeks following the birth. The schedule would include the core services of monitoring of child health, development and wellbeing; early identification of family risk and need; responding to identified needs; health promotion and disease prevention (for example, support for breastfeeding); and support for parenting. • Where the universal child and family health services identify a health or developmental issue or support need, the service will provide or identify a pathway for targeted care, such as an enhanced schedule of contacts and referral to allied health and specialist services. • Where a child requires more intensive care for a disability or developmental concerns, a care coordinator, associated with a primary health care service, would be available to coordinate the range of services these families often need. (RD 3.5, 3.6 & 3.7) 	<p>We suggest that the initial work on this will need to be a stock take of current programs, and should build on child and family health policy development.</p> <p>Consideration needs to be given as to how the development of these services will relate, as a discrete program, to the transfer of primary health care to Commonwealth responsibility and to other changes in primary health care.</p> <p>In conjunction with stock take undertaken in first 12 months, undertake work to estimate target populations, develop eligibility criteria, methods for identifying and referring service recipients, and develop transition plan for phased transition from existing services to a national program delivering on all reform directions by 2015.</p> <p>The key elements to be developed in parallel are:</p> <ul style="list-style-type: none"> • pre-conception (recommendation 23); • antenatal, early support, mothers and children with special needs, both general and targeted support services; (recommendations 23 & 24) • school related services (recommendation 25). • The development of all of these should be done on a dedicated basis, but in liaison with and having regard to the planning for the transfer of responsibility for state funded primary health care services to the Commonwealth. 	HAA	Commonwealth Government through COAG	DoHA working with state and territory departments responsible for existing programs, and key health professional groups and organisations including child and family health services, GPs, maternity services and Royal Australasian College of Physicians Chapter of Community Child Health.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
25. We recommend that all primary schools have access to a child and family health nurse for promoting and monitoring children's health, development and wellbeing, particularly through the important transition to primary school. (RD 3.8)				
26. We recommend that responsibility for nurturing a healthy start to life be embedded in primary health care to ensure a comprehensive understanding of a child's health needs and continuity of care. Families would have the opportunity to be enrolled with a primary health care service as this would enable well integrated and coordinated care and a comprehensive understanding of the health needs of children and their families. (RD 3.9)				
4. Ensuring timely access and safe care in hospitals				
27. We recommend development and adoption of National Access Targets for timeliness of care. For example: <ul style="list-style-type: none"> • a national access target for people requiring an acute mental health intervention (measured in hours); • a national access target for patients requiring urgent primary health care (measured in hours or days); • national access targets for people attending emergency departments (measured in minutes to hours) • a national access target for patients requiring coronary artery surgery or cancer treatment (measured in weeks/days); and • a national access target for patients requiring other planned surgery or procedures (measured in months). These National Access Targets should be developed incorporating clinical, economic and community perspectives through vehicles like citizen juries, and may evolve into National Access Guarantees subject to ensuring there is no distortion in allocation of resources to services. (RD 4.1)		HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA to establish process incorporating clinical, economic and community perspectives through vehicles like citizen juries. Clinical perspectives could be through clinical senates.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
28. A share of the funding potentially available to health services should be linked to meeting (or improving performance towards) the access targets, payable as a bonus. (RD 4.2)		HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	
29. We recommend there be financial incentives to reward good performance in outcomes and timeliness of care. One element of this should be for timely provision of suitable clinical information (such as discharge information) including details of any follow-up care required. (RD 4.3)	<ul style="list-style-type: none"> • Timeliness dealt with through National Access Targets (NATS). • Incentives for performance in outcomes need to be developed in conjunction with performance reporting to be developed as per recommendations 32 and 33. • Provision of electronic summary of care also covered by recommendation 120. 	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	All hospitals public and private to implement systems to meet target.
30. We recommend the use of activity-based funding for both public and private hospitals using casemix classifications (including the cost of capital). <ul style="list-style-type: none"> • This approach should be used for inpatient and outpatient treatment. • Emergency department services should be funded through a combination of fixed grants (to fund availability) and activity-based funding. 	<ul style="list-style-type: none"> • Data are already captured nationally which provide a basis for this for admitted patients and emergency department attendances, although action would need to be taken to ensure accuracy and timeliness, and emergency department attendances are not yet subject to casemix classification. • There are casemix classifications in use for payments for non admitted hospital services and some sub-acute services (rehabilitation) in Australia and overseas. However national data collection for non-admitted services would need to be developed as it would also for sub-acute care including rehabilitation. 	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA working with state and territory departments with input from key health professional groups and organisations including Australian Health care and Hospitals Association (AHPA).

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
30. (continued)	<ul style="list-style-type: none"> Commonwealth systems would need to be developed to collect data from states/hospitals as basis for payment. Payment would be prospective with subsequent adjustment for actual activity where necessary. Transition from population based grants to activity-based payments would need to be phased in over 3 years following a 2 year lead time to commence activity-based funding for admitted, non admitted and emergency department episodes of care, and further development required for sub-acute and rehabilitation. <p>Legislative changes required (to enable special appropriation for open ended payment per episode).</p>			
<ul style="list-style-type: none"> For hospitals with a major emergency department service the costs of having to maintain capacity to admit people promptly should be recognised in the funding arrangements. (RD 4. 4) 	<p>Define hospitals in scope.</p> <p>Level of payment to a hospital to be based upon the cost of maintaining a vacant bed ready for use, times the number of beds required to be vacant to achieve 15 per cent vacancy rate.</p>	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA working with state and territory departments with input from key health professional groups and organisations.
31. We recommend that all hospitals review provision of ambulatory services (outpatients) to ensure they are designed around patients' needs and, where possible, located in community settings. (RD 4.5)	Capital investment will also be required (recommendation 97).	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA working with state and territory departments with input from key health professional groups and organisations, in lead up to introduction of activity-based funding for non-admitted public hospital services. To have regard to models of shared care (see 20 above).

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
32. To support quality improvement we recommend that data on quality and safety should be collated, compared and provided back to hospitals, clinical units and clinicians in a timely fashion to expedite quality and quality improvement cycles. Hospitals should also be required to report on their strategies to improve safety and quality of care and actions taken in response to identified safety issues. (RD 4.6)	To apply to private and public hospitals. Requires technical development of indicators for national adoption, both initial and then continuing. Build on work that has already been done for indicators at the hospital level. There also exist some indicators and datasets already developed for use at the clinical unit level, often by relevant health professional groups, for example data for performance monitoring and improvement of intensive care units, for emergency departments, and obstetric and maternity units. Other relevant examples include the Variable Life Adjusted Display (VLAD) approach now taken for Queensland public hospitals. Legislative changes may be required if obligation is to be statutory or tied to statutory payments.	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA with ACSQHC, Australian Private Hospitals Association (APHA) and Australian Health Insurers' Association (AHIA) and state and territory departments in consultation with relevant health professional and hospital organisations and consumer representatives.
33. To improve accountability, we recommend that public and private hospitals be required to report publicly on performance against a national set of indicators which measure access, efficiency and quality of care provided. (RD 4.7)		HAA		
34. To better understand people's use of health services and health outcomes across different care settings we recommend that public and private hospital episode data should be collected nationally and linked to MBS and PBS data using a patient's Medicare card number. (RD 4.8)	To be undertaken with patient level data collection for activity-based payment, through Medicare Australia (see recommendation 30 above). De-identified patient level data to be routinely provided to: <ul style="list-style-type: none"> the AIHW to support its role in reporting national statistics the Commonwealth department in the same manner as MBS, PBS and aged care data currently; and to states and territories in respect of their public hospitals, if they wish. Legislative changes required	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA to work with state and territory departments and Medicare Australia.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
35. We recommend that the future planning of hospitals should encourage greater delineation of hospital roles including separation of planned and emergency treatment, and optimise the provision and use of public and private hospital services. (RD 4.9)	Relies on states and territories to adopt this approach.	HAA	States and territories, with commitment to do so as part of Healthy Australia Accord.	States and territories to develop state-wide hospital service plans.
36. We recommend a nationally led, systemic approach to encouraging, supporting and harnessing clinical leadership within hospitals and broader health settings and across professional disciplines. (RD 4.10)	Commonwealth to convene specially based clinical advisory committees in support of activity-based funding and as consultative bodies to support Commonwealth policy on clinical practice, including a national clinical senate possibly reporting to the Chief Medical Officer and the Chief Nursing and Midwifery Officer.	HAA	Commonwealth and states and territories, with commitment to do so as part of Healthy Australia Accord.	DoHA and states and territories to establish clinical senates and state-wide clinical networks.
5. Restoring people to better health and independent living				
37. The visibility of, and access to, sub-acute care services must be increased for people to have the best opportunity to recover from injury or illness and to be restored to independent living. To do this we recommend: <ul style="list-style-type: none"> • funding must be more directly linked to the delivery and growth of sub-acute services. • a priority focus should be the development of activity-based funding models for sub-acute services (including the cost of capital), supported by improvements in national data and definitions for sub-acute services. • the use of activity-based funding complemented by incentive payments related to improving outcomes for patients. (RD 5.1 & 5.2) 	<p>Development of activity-based funding, with improvements in national data and definitions of sub-acute services.</p> <p>As noted in recommendation 30 above, there are casemix classifications in use for payments for some sub-acute services (rehabilitation) in Australia as well as overseas. However national data collection would need to be developed as it would also for sub-acute care including rehabilitation. Need to select best classification(s) currently in use for activity-based payment – eg Casemix Rehabilitation and Funding Tree (CRAFT) (Vic) – to be used nationally.</p>	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA working with state and territory departments with input from key health professional groups and organisations.
		HAA	Commonwealth Government	DoHA working with state and territory departments with input from key health professional groups and organisations, to select measures to be used and data to be collected and design incentives.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
37. (continued)	Need to incorporate measures of functional capacity and other outcome measures of sub-acute care in national data collections to support development of incentive payments that reward improving outcome and/or slowing decline. Legislative changes required (as part of those required for recommendation 30, for sub-acute funding to be a special appropriation).			
38. We recommend that clear targets to increase provision of sub-acute services be introduced by June 2010. These targets should cover both inpatient and community-based services and should link the demand for sub-acute services to the expected flow of patients from acute services and other settings. Incentive funding under the National Partnership Payments could be used to drive this expansion in sub-acute services. (RD 5.3)		HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA in consultation with state and territory departments and key health professional groups and organisations.
39. We recommend that investment in sub-acute services infrastructure be one of the top priorities for the Health and Hospitals Infrastructure Fund. (RD 5.4)			Commonwealth Government	Health and Hospitals Infrastructure Fund
40. We recommend planning and action to ensure that we have the right workforce available and trained to deliver the growing demand for sub-acute services including in the community. Accordingly, we support the need for better data on the size, skill mix and distribution of this workforce including rehabilitation medicine specialists, geriatricians and allied health staff. (RD5.5)	Establish data collection and analyse needs for sub-acute care workforce. Need to review existing workforce data and establish what refinements and additional data may be needed.		Commonwealth Government	AIHW and National Clinical Education and Training Agency (NCETA)
41. We recognise the vital role of equipment, aids and other devices, in helping people to improve health functioning and to live as independently as possible in the community. We recommend affordable access to such equipment should be considered under reforms to integrated safety net arrangements. (RD 5.6)	See recommendation 94.			

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
6. Increasing choice in aged care				
42. We recommend that government subsidies for aged care should be more directly linked to people rather than places. As a better reflection of population need, we recommend the planning ratio transition from the current basis of places per 1000 people aged 70 or over to care recipients per 1000 people aged 85 or over. (RD 6.1)	<p>Unless ratio is changed commencing from 2010, there will be a drop in places per 1000 people aged 85 or over by as much as 10 per cent over the next few years. As with past changes to ratio, it will take some time for capacity to expand to meet the new ratio, especially where new facilities have to achieve planning approval and then be constructed.</p> <p>In addition to basing ratio on population aged 85 or over, the ratio is to change from a limit on places to a limit on the number of people receiving care subsidy at any one time.</p> <p>Many of the changes we propose will have a significant impact on aged care providers. For example, lifting restrictions on the number of places a provider can offer is a substantial change which will have significant effects on the asset valuations of many residential aged care providers. To avoid instability, we suggest that the Commonwealth Government develop with aged care providers and consumer and carer representatives, a five year transition plan. As part of this the sector should be given 5 years notice of the lifting of limits on numbers of places so that providers have time to adjust prior to the limits being lifted.</p>		Commonwealth Government	Commonwealth Government
43. We recommend that consideration be given to permitting accommodation bonds or alternative approaches as options for payment for accommodation for people entering high care provided that removing the regulated limits on the number of places has resulted in sufficient increased competition in supply and price. (RD 6.2)	Legislative changes required		Commonwealth Government	Commonwealth Government

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
44. We recommend requiring aged care providers to make standardised information on service quality and quality of life publicly available on agedcareaustralia.gov.au to enable older people and their families to compare aged care providers. (RD 6.3)	It is suggested that contribution of standard information be a requirement for accreditation.		Commonwealth Government	DoHA working with aged care providers and consumer representatives.
45. We recommend consolidating aged care under the Commonwealth Government by making aged care under the Home and Community Care (HACC) program a direct Commonwealth program. (RD 6.4)	There should be a transition period of 3 years during which existing HACC services continue to receive funding as they would have prior to the transfer, while planning for subsequent arrangements occurs. Legislative changes required	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA working with state and territory departments and HACC providers.
46. We recommend development and introduction of streamlined, consistent assessment for eligibility for care across all aged care programs. This should include: <ul style="list-style-type: none"> transferring the Aged Care Assessment Teams to Commonwealth responsibility; developing new assessment tools for assessing people's care needs; and integrating assessment for Home and Community Care Services with more rigorous assessment for higher levels of community and residential care (RD 6.5) 	Transfer of Aged Care Assessment Teams to become a direct Commonwealth program. Develop consistent assessments. Legislative changes required	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA in consultation with representatives of providers and consumers.
47. We recommend that there be a more flexible range of care subsidies for people receiving community care packages, determined in a way that is compatible with care subsidies for residential care. (RD 6.6)	It will take two or more years to develop, test and implement new methods of assessment for care subsidy. It is likely to require trials to gather data on performance of the possible assessments. Legislative changes required		Commonwealth Government	DoHA in consultation with representatives of providers and consumers.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
48. We recommend that people who can contribute to the costs of their own care should contribute the same for care in the community as they would for residential care (not including accommodation costs). (RD 6.7)	Legislative changes required		Commonwealth Government	DoHA in consultation with representatives of providers and consumers, Centrelink, Department of Veterans Affairs (DVA) and Medicare Australia required to be involved in implementation.
49. We recommend that people supported to receive care in the community should be given the option to determine how the resources allocated for their care and support are used. (RD 6.8)	Legislative changes required		Commonwealth Government	DoHA in consultation with representatives of consumers, carers and providers.
50. We recommend that once assessment processes, care subsidies and user payments are aligned across community care packages and residential care, older people should be given greater scope to choose for themselves between using their care subsidy for community or for residential care. (RD 6.9) Notwithstanding this, we note that given the increase in frailty and complexity of care needs, for many elderly people residential care will remain the best and only viable option for meeting their care needs. The level of care subsidies should be periodically reviewed to ensure they are adequate to meet the care needs of the most frail in residential settings. In the lead up to freeing up choice of care setting, there should be a phased plan over 5 years to enable aged care providers to convert existing low care residential places to community places.	Changes to be developed and introduced from 2013 to 2015 to ensure time to gain practical experience of new approaches to assessment and greater choice of provider and care received in community settings (49 above). Legislative changes required		Commonwealth Government	DoHA in consultation with representatives of consumers, carers and providers.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
51. We recommend that all aged care providers (community and residential) should be required to have staff trained in supporting care recipients to complete advance care plans for those who wish to do so. (RD 6.10)			Commonwealth Government	DoHA working with representatives of consumers, carers and aged care providers.
52. We recommend that funding be provided for use by residential aged care providers to make arrangements with primary health care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes. (RD 6.11)	Proposed to be a session per week per 60 occupied places.		Commonwealth Government to set parameters and provide funding.	Aged care providers working with GPs and geriatricians.
53. The safety, efficiency and effectiveness of care for older people in residential and community settings can be assisted by better and innovative use of technology and communication. We recommend: <ul style="list-style-type: none">• supporting older people, and their carers, with the person’s consent, to activate and access their own person-controlled electronic health record;• improved access to e-health, online and telephonic health advice by older people and their carers and home and personal security technology;• increased use of electronic clinical records and e-health enablers in aged care homes, including capacity for electronic prescribing by attending medical and other credentialled practitioners, and providing a financial incentive for electronic transfer of clinical data between services and settings (general practitioners, hospital and aged care), subject to patient consent; and• the hospital discharge referral incentive scheme must include timely provision of pertinent information on a person’s hospital care to the clinical staff of their aged care provider, subject to patient consent. (RD 6.12)	Aspects of this also dealt with in recommendation 120.	HAA	Commonwealth Government through COAG and Healthy Australia Accord	Aged care providers working with IT suppliers. Hospitals working with IT suppliers and aged care providers.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
7. Caring for people at the end of life				
54. We recommend building the capacity and competence of primary health care services, including Comprehensive Primary Health Care Centres and Services, to provide generalist palliative care support for their dying patients. This will require greater educational support and improved collaboration and networking with specialist palliative care service providers. (RD 7.1)	Development of continuing education modules across disciplines to achieve competencies in end of life care. Capacity (including staff with relevant competencies) to provide generalist palliative care and agreed arrangements with specialist palliative care services to be incorporated as part of assessment required for recognition of comprehensive primary health care services (see 17 above).		Commonwealth Government	DoHA in consultation with relevant academic and training bodies, consumer representatives and primary health providers. To be undertaken as part of recommendation 17 above.
55. We recommend strengthening access to specialist palliative care services for all relevant patients across a range of settings, with a special emphasis on people living in residential aged care facilities. (RD 7.2)	Increased funding of specialist palliative care services, linked to a specific requirement that people in different settings are explicitly eligible for specialist palliative care. This could build upon a needs-based assessment to access specialist palliative care services.		Commonwealth Government	DoHA in consultation with representatives of professions and relevant organisations, and working with state and territory departments.
56. We recommend that additional investment in specialist palliative care services be directed to support more availability of these services to people at home in the community. (RD 7.3)			Commonwealth Government	DoHA in consultation with representatives of professions and relevant organisations, and working with state and territory departments.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
57. We recommend that advance care planning be funded and implemented nationally commencing with all residential aged care services, and then being extended to other relevant groups in the population. This will require a national approach to education and training of health professionals including greater awareness and education among health professionals of the common law right of people to make decisions on their medical treatment, and their right to decline treatment. We note that, in some states and territories, this is complemented by supporting legislation that relates more specifically to end of life and advance care planning decisions. (RD 7.4 & 7.5)	Needs identification of existing effective advance care planning programs. Requires training of a minimum number of staff in each aged care facility to assist residents who wish to have an advance care plan, followed by training of staff in other settings. Requires a sensitive information campaign to promote advance care planning to the public, possibly directly, as well as through health professionals.		Commonwealth Government	DoHA working with aged care providers and state and territory departments DoHA working with proponents of advance care planning and health professionals DoHA in consultation with representatives of professions and relevant organisations, and working with state and territory departments
8. Closing the health gap for Aboriginal and Torres Strait Islander peoples				
58. We recommend that the Commonwealth Department of Health and Ageing take a lead in the inter-sectoral collaboration that will be required at the national level to redress the impacts of the social determinants of health to close the gap for Aboriginal and Torres Strait Islander peoples. (RD 8.1)			Commonwealth Government	DoHA in conjunction with other Commonwealth agencies and states and territories.
59. We recommend an investment strategy for Aboriginal and Torres Strait Islander people's health that is proportionate to health need, the cost of service delivery, and the achievement of desired outcomes. This requires a substantial increase on current expenditure. (RD 8.2)			Commonwealth Government	DoHA then the National Aboriginal and Torres Strait Islander Health Authority (NATSIHA).
60. We recommend strengthening and expanding organisational capacity and sustainability of Community Controlled Health Services to provide and broker comprehensive primary health care services. We recommend this should occur within OATSIH or a similar group within the Commonwealth Department of Health and Ageing but should be separate to the purchasing function. (RD 8.3)			Commonwealth Government	DoHA

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>61. Acknowledging that significant additional funding in Aboriginal and Torres Strait Islander health care will be required to close the gap, we recommend that a dedicated, expert commissioning group be established to lead this investment. This could be achieved by the establishment of a National Aboriginal and Torres Strait Islander Health Authority within the Health portfolio to commission and broker services specifically for Aboriginal and Torres Strait Islander people and their families as a mechanism to focus on health outcomes and ensure high quality and timely access to culturally appropriate care. (RD 8.4)</p>	<p>Establishment of Authority with initial staffing to develop detailed plan for transition to fully functioning body.</p> <p>(Implications for state and territory services and funding of Commonwealth becoming responsible for payment for all health services to Indigenous people opting into this approach, to be agreed through the Healthy Australia Accord)</p>	HAA	Commonwealth Government through COAG and Healthy Australia Accord.	DoHA initially, then NATSIHA, in partnership with representatives of Aboriginal And Torres Strait Islander people, and states and territories.
<p>62. We recommend that accreditation processes for health services and education providers incorporate, as core, specific Indigenous modules to ensure quality clinical and culturally appropriate services. (RD 8.5)</p>			Commonwealth Government	DoHA initially, then NATSIHA once established working with accreditation bodies, providers of clinical education and representatives of Aboriginal And Torres Strait Islander people.
<p>63. We recommend additional investment includes the funding of strategies to build an Aboriginal and Torres Strait Islander health workforce across all disciplines and the development of a workforce for Aboriginal and Torres Strait Islander health. (RD 8.6)</p>	<p>Increase course availability; encourage Aboriginal and Torres Strait Islander people into training and provide greater support to them while they are learning.</p>		Commonwealth Government	DoHA with NCETA working with representatives of Aboriginal and Torres Strait Islander people, and education providers.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
64. Good nutrition and a healthy diet are key elements of a healthy start to life. But many Aboriginal and Torres Strait Islander people living in remote areas have limited access to affordable healthy foods. We recommend an integrated package to improve the affordability of fresh food – particularly fruit and vegetables – in these targeted remote communities. This package would include subsidies to bring the price of fresh food in line with large urban and regional centres, investment in nutrition education and community projects, and food and nutrient supplementation for schoolchildren, infants, and pregnant and breastfeeding women. The strategy would be developed in consultation with these Aboriginal and Torres Strait Islander communities, building on some of the successful work already underway. There would be an evaluation to assess the benefits of extending the program to other communities, focusing on the changes to eating habits and improvements to health. (New)			Commonwealth Government	DoHA
9. Delivering better health outcomes for remote and rural communities				
65. Flexible funding arrangements are required to reconfigure health service delivery to achieve the best outcomes for the community. To facilitate locally designed and flexible models of care in remote and small rural communities, we recommend:				
<ul style="list-style-type: none"> funding equivalent to national average medical benefits and primary health care service funding, appropriately adjusted for remoteness and health status, be made available for local service provision where populations are otherwise under-served; and 	<p>Work required to define eligibility (ie regions which are underserved) and processes for instigating it.</p> <p>Significant work may also be needed to define requirements, and any rules around uses of the funds, etc.</p> <p>Could be done using Health Program Grants provision of Health Insurance Act.</p>		Commonwealth Government	DoHA in consultation with rural/remote communities, and state and territories.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<ul style="list-style-type: none"> expansion of the multi-purpose service model to towns with catchment populations of approximately 12,000. (RD 9.1) 		HAA	Commonwealth Government through COAG and Healthy Australia Accord.	DoHA working with states and territories, in consultation with rural communities.
66. Care for people in remote and rural locations necessarily involves bringing care to the person or the person to the care. To achieve this we recommend:				
<ul style="list-style-type: none"> networks of primary health care services, including Aboriginal and Torres Strait Islander Community Controlled Services, within naturally defined regions; 	These need to be developed in conjunction with Commonwealth taking responsibility for primary health care (16 above).		Commonwealth Government	DoHA working with primary health care services to promote the formation of networks.
<ul style="list-style-type: none"> expansion of specialist outreach services – for example, medical specialists, midwives, allied health, pharmacy and dental/oral health services; 			Commonwealth Government	DoHA – to expand scope of the specialist outreach services, working with rural communities and health professional groups.
<ul style="list-style-type: none"> telehealth services including practitioner-to-practitioner consultations, practitioner-to-specialist consultations, teleradiology and other specialties and services; 	Legislative changes likely to be required in respect of MBS benefits for telehealth services.	HAA	Commonwealth Government and state and territory governments through Healthy Australia Accord.	DoHA to develop approaches that recognise telehealth in private practice rebates and activity-based funding of non-admitted hospital services. States and territories to incorporate telehealth in hospital service delivery.
<ul style="list-style-type: none"> referral and advice networks for remote and rural practitioners that support and improve the quality of care, such as maternity care, chronic and complex disease care planning and review, chronic wound management, and palliative care; 			Commonwealth Government and state and territory governments.	DoHA working with health professional bodies.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<ul style="list-style-type: none"> • ‘on-call’ 24-hour telephone and internet consultations and advice, and retrieval services for urgent consultations staffed by remote medical practitioners. 			Commonwealth Government and state and territory governments.	DoHA working with states and territories and service providers.
Further, we recommend that funding mechanisms be developed to support all these elements. (RD 9.2)			Commonwealth Government and state and territory governments.	DoHA working with states and territories in consultation with service providers.
67. We recommend that a patient travel and accommodation assistance scheme be funded at a level that takes better account of the out-of-pocket costs of patients and their families and facilitates timely treatment and care. (RD 9.3)		HAA	Commonwealth Government and state and territory governments.	DoHA working with states and territories.
68. We recommend that a higher proportion of new health professional educational undergraduate and postgraduate places across all disciplines be allocated to remote and rural regional centres, where possible in a multidisciplinary facility built on models such as clinical schools or university departments of Rural Health. (RD 9.4)			Commonwealth Government	DoHA working with education providers and health professional bodies.
69. We recommend building health service, clinical and workforce capability through a remote and rural health research program. (New)			Commonwealth Government	DoHA
70. We recommend that the Clinical Education and Training Agency take the lead in developing <ul style="list-style-type: none"> • an integrated package of strategies to improve the distribution of the health workforce. This package could include strategies such as providing university fee relief, periodic study leave, locum support, expansion of medical bonded scholarships and extension of the model to all health professions. 	Note the recently announced National Health Workforce Agency will fulfil some of the roles described. However the National Clinical Education and Training Agency we recommend is broader in scope.		Commonwealth Government	NCETA once established.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<ul style="list-style-type: none"> preferential access for remote and rural practitioners to training provided by specialty colleges recognising related prior learning and clinical experience and/or work opportunities for practitioners returning to the city and support for those who plan to return again to remote or rural practice once specialty attained. (New) 				
10. Supporting people living with mental illness				
71. We recommend that a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service. (RD 10.1)		HAA	Commonwealth Government through COAG via Healthy Australia Accord.	DoHA working with state and territory departments.
72. We recommend that the Early Psychosis Prevention and Intervention Centre model be implemented nationally so that early intervention in psychosis becomes the norm. (RD 10.2)		HAA	Commonwealth Government through COAG via Healthy Australia Accord.	DoHA working with state and territory departments.
73. We recommend that every acute mental health service have a rapid-response outreach team for those individuals experiencing psychosis, and subsequently have the acute service capacity to provide appropriate treatment. (RD 10.3)	Will require collaboration with law enforcement agencies to ensure access to emergency services personnel appropriately trained in mental health issues.	HAA	Commonwealth Government through COAG via Healthy Australia Accord.	DoHA working with state and territory departments.
74. We recommend that every hospital-based mental health service should be linked with a multi-disciplinary community-based sub-acute service that supports 'stepped' prevention and recovery care. (RD 10.4)		HAA	Commonwealth Government through COAG via Healthy Australia Accord.	DoHA working with state and territory departments.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
75. We strongly support greater investment in mental health competency training for the primary health care workforce, both undergraduate and postgraduate, and that this training be formally included as part of curricula accreditation processes. (RD 10.5)		HAA	Commonwealth Government through COAG via Healthy Australia Accord.	DoHA working with state and territory departments.
76. We recommend that each state and territory government provide those suffering from severe mental illness with stable housing that is linked to support services. (RD 10.6)			State and territory governments.	State and territory public housing departments.
77. We want governments to increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support. (RD 10.7)			Commonwealth Government	Commonwealth Department of Education Employment and Workplace Relations, with Family Community Services and Indigenous Affairs.
78. As a matter of some urgency, governments must collaborate to develop a strategy for ensuring that older Australians, including those residing in aged care facilities, have adequate access to specialty mental health and dementia care services. (RD 10.8)		HAA	Commonwealth Government through COAG via Healthy Australia Accord.	DoHA working with state and territory departments of health.
79. We recommend that state and territory governments recognise the compulsory treatment orders of other Australian jurisdictions. (RD 10.9)	Legislative changes likely to be required (to state acts to support mutual recognition)	HAA	Commonwealth Government through COAG via Healthy Australia Accord.	Standing Committee of Attorneys-General
80. We recommend that health professionals should take all reasonable steps in the interests of patient recovery and public safety to ensure that when a person is discharged from a mental health service that:				

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<ul style="list-style-type: none"> there is clarity as to where the person will be discharged; and someone appropriate at that location is informed. (RD 10.10) 			State and territory governments.	State and territory departments and health services to develop and adopt new protocols.
81. We recommend a sustained national community awareness campaign to increase mental health literacy and reduce the stigma attached to mental illness. (RD 10.11)		HAA	Commonwealth Government through COAG via Healthy Australia Accord.	DoHA
82. We acknowledge the important role of carers in supporting people living with mental disorders. We recommend that there must be more effective mechanisms for consumer and carer participation and feedback to shape programs and service delivery. (RD 10.12)	Mental health services to implement patient and carer experience surveys.	HAA	Commonwealth Government through COAG via Healthy Australia Accord.	State and territory departments.
11. Improving oral health and access to dental care				
83. We recommend that all Australians should have universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay. This should occur through the establishment of the 'Denticare Australia' scheme. Under the 'Denticare Australia' scheme people will be able to select between private or public dental health plans. 'Denticare Australia' would meet the costs in both cases. The additional costs of Denticare could be funded by an increase in the Medicare Levy of 0.75 per cent of taxable income. (RD 11.1, 11.2 & 11.3)	<p>Establishment of Denticare Australia will require development of:</p> <ul style="list-style-type: none"> the detailed schedule of preventive, restorative and denture services to be covered under Denticare, to be incorporated in regulations governing the scheme; actuarial risk adjustment to determine the premiums to be paid by the government for people opting for a dental plan. These should include consideration as to whether a scheme for risk equalisation based on claims experience after the fact is also required; 	HAA	Commonwealth Government through COAG via Healthy Australia Accord in relation to state public dental programs.	DoHA in consultation with states and territories, health professional bodies and private health insurers. [Levy: DoHA working with Treasury]

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
83. (continued)	<ul style="list-style-type: none"> regulations, including prudential requirements and complaints mechanisms, to govern organisations offering dental plans and accepting premiums. These may simply adapt existing arrangements for Private Health Insurers. <p>Legislation required. Denticare will require a statutory basis.</p>			
84. We recommend the introduction of a one-year internship scheme prior to full registration, so that clinical preparation of oral health practitioners (dentists, dental therapists and dental hygienists) operates under a similar model to medical practitioners. We recognise that this will require an investment in training and capital infrastructure. (RD 11.4)	<p>This intern year is to be undertaken chiefly in public dental services. To establish this internship will in turn require:</p> <ul style="list-style-type: none"> agreement between tertiary education providers and public dental services; capital funding to increase the facilities available in public dental clinics for use in training interns. <p>Some placements with private dental services may be appropriate.</p>	HAA	Commonwealth Government through COAG via Healthy Australia Accord.	DoHA working with education providers, health professional bodies and state and territory departments.
85. We recommend the national expansion of the pre-school and school dental programs. (RD 11.5)	This will require review of existing programs nationally to determine what is currently provided and what the national program should offer.	HAA	Commonwealth Government through COAG via Healthy Australia Accord.	DoHA working with state and territory dept of health, in consultation with state and territory departments of education.
86. We recommend that additional funding be made available for improved oral health promotion, with interventions to be decided based upon relative cost-effectiveness assessment. (RD 11.6)		HAA	Commonwealth Government through COAG via Healthy Australia Accord.	DoHA then NHPPA once established.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
12. Strengthening the governance of health and health care				
87. To give effect to a national health system, we recommend that First Ministers agree to a new Healthy Australia Accord that will clearly articulate the agreed and complementary roles and responsibilities of all governments in improving health services and outcomes for the Australian population.	We suggest that the COAG should agree in 2009 to the development of the Healthy Australia Accord, with a view to agreeing the Accord in 2010.	HAA	Commonwealth Government through COAG to establish Healthy Australia Accord	DoHA working with states and territory departments to achieve orderly transfer of responsibilities to national mechanisms, including drafting national legislation and amending or repealing state and territory legislation.
88. The Healthy Australia Accord would incorporate the following substantial structural reforms to the governance of the health system:		HAA	Commonwealth Government through COAG to establish Healthy Australia Accord.	
88.1 The Commonwealth Government would assume full responsibility for the policy and public funding of primary health care services. This includes all existing community health, public dental services, family and child health services, and alcohol and drug treatment services that are currently funded by state, territory and local governments.	See also recommendation 16.	HAA	Commonwealth Government	
88.2 The Commonwealth and state and territory governments would move to new transparent and more equitable funding arrangements for public hospitals and public health care services as follows: <ul style="list-style-type: none"> The Commonwealth Government would meet 100 per cent of the efficient costs of public hospital outpatient services using an agreed casemix classification and an agreed, capped activity-based budget. 	See also recommendation 30. We suggest the Accord should include a target date for the first activity-based payments to commence, in relation to public acute inpatients, of 1 July 2011, with phasing in of other payments to be largely completed by mid 2015.	HAA	Commonwealth Government	

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<ul style="list-style-type: none"> The Commonwealth Government would pay 40 per cent of the efficient cost of care for every episode of acute care and sub-acute care for public patients admitted to a hospital or public health care facility for care, and for every attendance at a public hospital emergency department. 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. 				
88.3 The Commonwealth Government would 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.	See also recommendations 95 and 101.	HAA	Commonwealth Government	

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
88.4 The Commonwealth Government would assume full responsibility for the purchasing of all health services for Aboriginal and Torres Strait Islander people through the establishment of a National Aboriginal and Torres Strait Islander Health Authority. This would include services that are provided through mainstream and community-controlled health services, including services that are currently funded by state, territory and local governments.	See also recommendation 61.		Commonwealth Government	
88.5 The Commonwealth Government would assume full responsibility for providing universal access to dental care (preventive, restorative and dentures). This would occur through the establishment of the 'Denticare Australia' scheme.	See also recommendation 83.	HAA	Commonwealth Government	
88.6 The Commonwealth Government would assume full responsibility for public funding of aged care. This would include the Home and Community Care Program for older people and aged care assessment.	See also recommendation 46.	HAA	Commonwealth Government	
88.7 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.		HAA	Commonwealth Government	
88.8 These changes to roles and responsibilities allow for the continued involvement of states, territories and local governments in providing health services.		HAA		

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>88.9 The Commonwealth, state and territory governments would agree to establish national approaches to health workforce planning and education, professional registration, patient safety and quality (including service accreditation), e-health, performance reporting (including the provision of publicly available data on the performance of all aspects of the health system), prevention and health promotion, private hospital regulation and health intervention and technology assessment. (RD 12.1)</p>	<p>First step will be to prepare a review of current situation in each area where a new national approach or body is proposed; how the function will be carried out and by whom, what organisational arrangements need to be established and what legislative changes are required.</p> <p>For some functions such as a permanent Safety and Quality Commission, it may only require making the existing body permanent with continuing funding.</p> <p>Legislative changes required. For new national regulatory functions superseding existing state functions there will need to be an orderly transfer of regulatory responsibilities, including drafting of national legislation and amending or repealing state and territory legislation.</p>	HAA		
<p>89. We believe that there is a real need to further improve the responsiveness and efficiency of the health system and capacity for innovation. We agree that greater consumer choice and provider competition and better use of public and private health resources could offer the potential to achieve this, through the development of a uniquely Australian governance model for health care that builds on and expands Medicare. This new model is based on the establishment of health and hospital plans, and draws upon features of social health insurance as well as encompassing ideas of consumer choice, provider competition and strategic purchasing. We have given this new governance model the working title 'Medicare Select'.</p>			Commonwealth Government	

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>90. We recommend that the Commonwealth Government commits to explore the design, benefits, risks and feasibility around the potential implementation of health and hospital plans to the governance of the Australian health system. This would include examination of the following issues:</p> <p>90.1 The basis for determination of the universal service entitlement to be provided by health and hospital plans (including the relationship between the Commonwealth Government and health and hospital plans with regard to growth in the scope, volume, and costs of core services, the process for varying the level of public funding provided to the health and hospital plans for purchasing of core services; and the nature of any supplementary benefits that might be offered by plans);</p> <p>90.2 The scope, magnitude, feasibility and timing of financial transfers between state, territory and local governments and the Commonwealth Government in order to achieve a single national pool of public funding to be used as the basis for funding health and hospital plans;</p> <p>90.3 The basis for raising financing for health and hospital plans (including the extent to which transparency should be promoted through use of a dedicated levy or through publicly identifying the share of consolidated revenue that makes up the universal service entitlement);</p>	<p>In parallel we recommend that over the next two years the Commonwealth explore the concept of 'Medicare Select' including the design, benefits, risks and feasibility of introducing competing health and hospital plans.</p>		Commonwealth Government	DoHA

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>90.4 The potential impact on the use of public and private health services including existing state and territory government funded public hospitals and other health services (incorporating consideration of whether regulatory frameworks for health and hospital plans should influence how plans purchase from public and private health services including whether there should be a requirement to purchase at a default level from all hospitals and primary health care services);</p> <p>90.5 The approach to ensuring an appropriate level of investment in capital infrastructure in public and private health services (including different approaches to the financing of capital across public and private health services and the treatment of capital in areas of market failure);</p> <p>90.6 The relationship between the health and hospital plans and the continued operation of the Medicare and Pharmaceutical Benefit Schemes (including whether there should continue to be national evaluation, payment and pricing arrangements and identifying what flexibility in purchasing could be delegated to health and hospital plans concerning the coverage, volume, price and other parameters in their purchasing of medical and pharmaceutical services in hospitals and the community);</p> <p>90.7 The potential role of private health insurance alongside health and hospital plans (including defining how private health insurance would complement health and hospital plans, the potential impact on membership, premiums, insurance products and the viability of existing private health insurance; and any changes to the Commonwealth Government's regulatory, policy or financial support for private health insurance);</p>				

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>90.8 The potential roles of state, territory and local governments under health and hospital plans (including issues related to the handling of functions such as operation of health services, employment of staff, industrial relations and the implications for transmission of business and any required assumption of legislative responsibility by the Commonwealth Government related to these changed functions, together with the operation by state and territory governments of health and hospital plans);</p> <p>90.9 The range of responsibilities and functions to be retained or assumed by Australian governments (and not delegated to health and hospital plans) in order to ensure national consistency or to protect 'public good' functions (including, as potential examples, functions such as health workforce education and training, research, population and public health and bio security);</p> <p>90.10 The approach to ensuring equitable access to health services in areas of market failure including in remote and rural areas of Australia (including the relevant roles of health and hospital plans in regard to the development and capacity building of a balanced supply and distribution of health services, and the approach by plans to regional and local consultation and engagement on population needs);</p>				

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>90.11 The necessary regulatory framework to support the establishment and operation of health and hospital plans (including issues relating to entry and exit of plans, minimum standards for the establishment of plans, any requirements relating to whether plans are able to also provide health services, and the potential separation of health and hospital plans and existing private health insurance products);</p> <p>90.12 The development of appropriate risk-adjustment mechanisms to protect public funding and consumers (including potential mechanisms such as the use of risk-adjusted payments by the Commonwealth Government to health and hospital plans, reinsurance arrangements and risk-sharing arrangements related to scope, volume and cost of services covered under health and hospital plans);</p> <p>90.13 The necessary regulatory framework to protect consumers (including potential requirements around guaranteed access, portability, co-payments, information provision on any choices or restrictions relating to eligible services and health professionals/health services covered under individual health and hospital plans, measures to regulate anti-competitive behaviours and complaints mechanisms). (New)</p>				

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
13. Raising and spending money for health services				
91. Health and aged care spending is forecast to rise to 12.4 per cent of gross domestic product in 2032–33. We believe that: <ul style="list-style-type: none"> • major reforms are needed to improve the outcomes from this spending and national productivity and to contain the upward pressure on health care costs; and • improved health outcomes are vital in promoting a healthy economy through greater productivity and higher labour force participation; and • evidence-based investment in strengthened primary health care services and prevention and health promotion to keep people healthy is required to help to contain future growth in spending. (RD 13.1) 			Commonwealth Government	
92. We want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade. (RD 13.2)			Commonwealth Government	
93. We recommend a systematic mechanism to formulating health care priorities that incorporates clinical, economic and community perspectives through vehicles like citizen injuries. (RD 13.3)		HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA working with state and territory departments of health.
94. We recommend a review of the scope and structure of safety net arrangements to cover a broader range of health costs. We want an integrated approach that is simpler and more family-centred to protect families and individuals from unaffordably high out-of-pocket costs of health care. (RD 13.4)	Legislative changes required if existing MBS and PBS safety nets affected.			

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>95. We recommend that incentives for improved outcomes and efficiency should be strengthened in health care funding arrangements.</p> <p>This will involve a mix of:</p> <ul style="list-style-type: none"> • activity-based funding (e.g. fee for service or casemix budgets). This should be the principal mode of funding for hospitals; • payments for care of people over a course of care or period of time. There should be a greater emphasis on this mode of funding for primary health care; and • payments to reward good performance in outcomes and timeliness of care. There should be a greater emphasis on this mode of funding across all settings. <p>We further recommend that these payments should take account of the cost of capital and cover the full range of health care activities including clinical education.</p> <p>(RD 13.5)</p>	<p>It is assumed that the states and territories would mirror the efficient activity-based pricing in purchasing arrangements with the public hospitals and health services they operate.</p> <p>See also recommendations 30, 37, 95 and 101.</p> <p>See also recommendations 18, 19, 28 and 29.</p> <p>See also recommendation 18.</p> <p>See also recommendations 95, 100 and 101.</p>	HAA	Commonwealth Government	
<p>96. We believe that funding arrangements may need to be adjusted to take account of different costs and delivery models in different locations and to encourage service provision in under-served locations and populations.</p> <p>(RD 13.6)</p>		HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA to establish systematic review of relative costs of service delivery to underserved locations and populations.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>97. Additional capital investment will be required on a transitional basis to facilitate our reform directions. In particular, we recommend that: priority areas for new capital investment should include:</p> <ul style="list-style-type: none"> • the establishment of Comprehensive Primary Health Care Centres; • an expansion of sub-acute services including both inpatient and community-based services; • investments to support expansion of clinical education across clinical service settings; and • targeted investments in public hospitals to support reshaping of roles and functions, clinical process redesign and a reorientation towards community-based care; and • capital can be raised through both government and private financing options. <p>The ongoing cost of capital should be factored into all service payments. (RD 13.7)</p>		HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA working with state and territory departments of health to develop capital funding and capital incentives program.
14. Working for us: a sustainable health workforce for the future				
<p>98. We recommend supporting our health workforce by:</p> <ul style="list-style-type: none"> • Promoting a culture of mutual respect and patient focus of all health professions through shared values, management structures, compensation arrangements, shared educational experiences and clinical governance processes that support team approaches to care; • Supporting effective communication across all parts of the health system; 	Many groups across the health system including hospitals and other health services, universities, DoHA, state and territory health departments, ACSQHC, NICS, NHMRC, professional and industry bodies such as AHHA, the private sector including APHA and AHIA, and health service managers across the system can contribute to this important group of actions.	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	DoHA with state and territory departments and relevant industry bodies and health service enterprises.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<ul style="list-style-type: none"> Investing in management and leadership skills development and maintenance for managers and clinicians at all levels of the system; Promoting quality and a continuous improvement culture by providing opportunities and encouraging roles in teaching, research, quality improvement processes, and clinical governance for all health professionals across service settings; providing timely relevant data on comparative clinical performance and latest practice knowledge to support best practice and continuous quality improvement; Improve clinical engagement through mechanisms to formally and informally involve all health professionals in guiding the management and future directions of health reform including establishing Clinical Senates at national, regional and local levels, subject specific taskforces and conducting health workforce opinion surveys; and 				
<ul style="list-style-type: none"> Recognise and support the health needs of health workers including setting the benchmark for best practice in workplace health programs.(RD 14.1) 		HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>99. To improve access to care and reflect current and evolving clinical practice we recommend that:</p> <ul style="list-style-type: none"> • Medicare rebates should apply to relevant diagnostic services and specialist medical services ordered or referred by nurse practitioners and other health professionals having regard to defined scopes of practice determined by recognised health professional certification bodies. • Pharmaceutical Benefits Scheme subsidies (or, where more appropriate, support for access to subsidised pharmaceuticals under section 100 of the National Health Act 1953) should apply to pharmaceuticals prescribed from approved formularies by nurse practitioners and other registered health professionals according to defined scopes of practice. • Where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialled for defined scopes of practice. • The Medicare Benefits Schedule should apply to specified activities performed by a nurse practitioner, midwife or other competent health professional, credentialled for defined scopes of practice, and where collaborative team models of care with a general practitioner, specialist or obstetrician are demonstrated. (RD 2.7 & 14.2 modified) 	<p>Beyond initiatives taken in 2009 budget, work is required to define:</p> <ol style="list-style-type: none"> 1. specified services and items covered; 2. evidence of safety and relative cost-effectiveness of work performed by competent health professionals; 3. recognition of certification bodies for the purpose of certifying competency for defined scopes of practice; and 4. definition of how collaborative team models of care will be demonstrated. <p>Legislative changes required</p>		Commonwealth Government	DoHA in consultation with relevant professions.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>100. We recommend a new framework for all education and training of health professionals:</p> <ul style="list-style-type: none"> • moving towards a flexible, multi-disciplinary approach to the education and training of all health professionals; • incorporating an agreed competency-based framework within broad teaching and learning curricula for all health professionals. • establishing a dedicated funding stream for clinical placements for undergraduate and postgraduate students; and • ensuring clinical training infrastructure across all settings (public and private, hospitals, primary health care and other community settings). (RD 14.3) 	<p>Legislative changes will be required to acts and regulations covering registration and recognition of rights to practice and eligibility of services for rebates.</p> <p>This should be developed with an efficient activity-based funding approach.</p> <p>Suggest a review of clinical training infrastructure be undertaken reporting to Commonwealth Government/COAG in 2011.</p>	HAA	<p>Commonwealth Government</p> <p>Commonwealth Government through COAG as part of Healthy Australia Accord.</p> <p>Commonwealth Government through COAG as part of Healthy Australia Accord.</p>	<p>DoHA working with NCETA, education providers, health professional bodies and state and territory departments.</p> <p>DoHA working with NCETA, education providers, health professional bodies, state and territory departments.</p> <p>DoHA/NCETA</p>
<p>101. To ensure better collaboration, communication and planning between the health services and health education and training sectors we recommend the establishment of a National Clinical Education and Training Agency:</p> <ul style="list-style-type: none"> • to advise on the education and training requirements for each region; • to assist with planning clinical education infrastructure across all service settings including rural and remote areas; 	<p>Legislation may be required</p> <p>As noted in Chapter 5, these functions could be included in the new National Health Workforce Agency recently agreed by governments.</p>	HAA	<p>Commonwealth Government through COAG as part of Healthy Australia Accord.</p>	<p>DoHA working with education providers, health professional bodies and state and territory departments.</p>

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<ul style="list-style-type: none"> to form partnerships with local universities, vocational education and training organisations, and professional colleges, to acquire clinical education placements from health service providers, including a framework for activity-based payments for undergraduates' clinical education and postgraduate training; to promote innovation in education and training of the health workforce; as a facilitator for the provision of modular competency-based programs to up-skill health professionals (medical, nursing, allied health and aboriginal health workers) in regional, rural and remote Australia; and to report every three years on the appropriateness of accreditation standards in each profession in terms of innovation around meeting the emerging health care needs of the community. <p>Further we recommend that the governance, management and operations of the Agency should include a balance of clinical and educational expertise, public and private health services representation in combination with Commonwealth and state health agencies.</p> <p>While the Agency has an overarching leadership function it should support implementation and innovation at the local level. (RD 14.4)</p>				
102. We support national registration to benefit the delivery of health care across Australia. (RD 14.5)	Already being undertaken. Will need to be modified in future to base registration on competencies, once competency framework established.		Commonwealth Government through COAG.	

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>103. We recommend implementing a comprehensive national strategy to recruit, retain and train Aboriginal and Torres Strait Islander health professionals at the undergraduate and postgraduate level including:</p> <ul style="list-style-type: none"> • setting targets for all education providers, with reward payments for achieving health professional graduations; • funding better support for Aboriginal and Torres Strait Islander health students commencing in secondary education; and • strengthening accrediting organisations' criteria around cultural safety. (RD 14.6) 				
<p>104. We recommend that a higher proportion of new health professional educational undergraduate and postgraduate places across all disciplines be allocated to remote and rural regional centres, where possible in a multidisciplinary facility built on models such as clinical schools or university departments of Rural Health. (RD 14.7)</p>		HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	NCETA working with education providers, health professional bodies and state and territory departments.
15. Fostering continuous learning in our health care system				
<p>105. To promote research and uptake of research findings in clinical practice, we recommend that clinical and health services research be given higher priority. In particular we recommend that the Commonwealth increase the availability of part-time clinical research fellowships across all health sectors to ensure protected time for research to contribute to this endeavour. (RD 15.1)</p>			Commonwealth Government	National Health and Medical Research Council (NHMRC).
<p>106. We recommend greater investment in public health, health policy, health services and health system research including ongoing evaluation of health reforms. (New)</p>	Provide as a dedicated stream of National Health and Medical Research Council funding with appropriate expert oversight of the new granting process including outcome reports.	HAA	Commonwealth Government through COAG as part of HAA	NHMRC to factor into all grants using an agreed approach

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
107. We further recommend that infrastructure funding (indirect costs) follow direct grants whether in universities, independent research institutes, or health service settings. (RD 15.2)				
108. We believe that the National Health and Medical Research Council should consult widely with consumers, clinicians and health professionals to set priorities for collaborative research centres and supportive grants which: <ul style="list-style-type: none"> • integrate multidisciplinary research across care settings in a 'hub and spoke' model; and • have designated resources to regularly disseminate research outcomes to health services. (RD 15.3) 		NHMRC	NHMRC	NHMRC in consultation with consumers, clinicians and health professionals.
109. To enhance the spread of innovation across public and private health services, we recommend that: <ul style="list-style-type: none"> • the National Institute of Clinical Studies broaden its remit to include a 'clearinghouse' function to collate and disseminate innovation in the delivery of safe and high quality health care; • health services and health professionals share best practice lessons by participating in forums such as breakthrough collaboratives, clinical forums, health roundtables, and the like; and • a national health care quality innovation awards program is established. (RD 15.4) 	Need to consider possible role of existing bodies such as Australian Research Centre for Health Innovation (www.archi.net.au) previously established with Commonwealth funding		Commonwealth Government	NICS
110. To help embed a culture of continuous improvement, we recommend that a standard national curriculum for safety and quality is built into education and training programs as a requirement of course accreditation for all registrable health professionals. (RD15.5)		HAA	Commonwealth Government	ACSQHC

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>111. The Australian Commission for Safety and Quality in Health Care should be established as a permanent, independent national body. With a mission to measurably improve the safety and quality of health care the ACS&QHC would be an authoritative knowledge-based organisation responsible for:</p> <p>Promoting a culture of safety and quality across the system:</p> <ul style="list-style-type: none"> • disseminating and promoting innovation, evidence and quality improvement tools; • recommending national data sets with a focus on the measurement of safety and quality; • identifying and recommending priorities for research and action; • advocating for safety and quality; • providing advice to governments, bodies (e.g. NHMRC, TGA), clinicians and managers on 'best practice' to drive quality improvement <p>Analysing and reporting on safety and quality across all health settings:</p> <ul style="list-style-type: none"> • reporting and public commentary on policies, progress and trends in relation to safety and quality • develop and conduct national patient experience surveys • report on patient reported outcome measures <p>Monitoring and assisting in regulation for safety and quality:</p> <ul style="list-style-type: none"> • recommending nationally agreed standards for safety and quality, including collection and analysis of data on compliance against these standards. The extent of such regulatory responsibilities requires further consideration of other compliance activities such as accreditation and registration processes. (RD 15.6) 	<p>Legislation may be required</p> <p>Initial clinical indicators of safety and quality of care have been under development by the ACSQHC for some time and should be available by the end of 2009.</p> <p>The confirmation of the ACSQHC as a permanent body should be achieved in 2010.</p>	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	ACSQHC

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>112. To drive improvement and innovation across all areas of health care, we believe that a nationally consistent approach is essential to the collection and comparative reporting of indicators which monitor the safety and quality of care delivery across all sectors. This process should incorporate:</p> <ul style="list-style-type: none"> • local systems of supportive feedback, including to clinicians, teams and organisations in primary health services and private and public hospitals; and • incentive payments that reward safe and timely access, continuity of care (effective planning and communication between providers) and the quantum of improvement (compared to an evidence base, best practice target or measured outcome) to complement activity-based funding of all health services. (RD 15.7) 		HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	ACSQHC and AIHW working with health departments, health professional bodies, AHHA, AHIA and APHA.
<p>113. We also recommend that a national approach is taken to the synthesis and subsequent dissemination of clinical evidence/research which can be accessed via an electronic portal and adapted locally to expedite the use of evidence, knowledge and guidelines in clinical practice. (RD 15.8)</p>		HAA	Commonwealth Government	DoHA working with ACSQHC, state and territory departments.
<p>114. As part of accreditation requirements, we believe that all hospitals, residential aged care services and Comprehensive Primary Health Care Centres and Services should be required to publicly report on progress with quality improvement and research. (RD 15.9)</p>	Health service accreditation bodies will need to incorporate this.	HAA	Commonwealth Government through COAG as part of Healthy Australia Accord.	NICS and ACSQHC.
				ACSQHC and DoHA and state and territory departments to include requirements in all funding arrangements and program reporting requirements.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
16. Implementing a national e-health system				
115. We recommend that, by 2012 every Australian should be able to: <ul style="list-style-type: none"> • have a personal electronic health record that will at all times be owned and controlled by that person; • approve designated health care providers and carers to have authorised access to some or all of their personal electronic health record; and • choose their personal electronic health record provider. (RD 16.1) 			Commonwealth Government	National Electronic Health Transition Authority (NEHTA)
116. We recommend that the Commonwealth Government legislate to ensure the privacy of a person's electronic health data, while enabling secure access to the data by the person's authorised health providers.	Requires legislative change		Commonwealth Government	DoHA to draft legislation in consultation with state and territory departments.
117. We recommend that the Commonwealth Government introduce: <ul style="list-style-type: none"> • unique personal identifiers for health care by 1 July 2010; unique health professional identifiers (HPI-I), beginning with all nationally registered health professionals, by 1 July 2010; • a system for verifying the authenticity of patients and professionals for this purpose – a national authentication service and directory for health (NASH) – by 1 July 2010; • a system for verifying the authenticity of patients and professionals for this purpose – a national authentication service for health (NASH) – by 1 July 2010; and • unique health professional organisation (facility and health service) identifiers (HPI-O) by 1 July 2010. 	Legislative changes required as part of recommendation 116.			
			Commonwealth Government	NEHTA and Medicare Australia.
			Commonwealth Government	NEHTA and Medicare Australia.
			Commonwealth Government	NEHTA and Medicare Australia.
			Commonwealth Government	NEHTA and Medicare Australia.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
118. We recommend that the Commonwealth Government develop and implement an appropriate national social marketing strategy to inform consumers and health professionals about the significant benefits and safeguards of the proposed e-health approach. (RD 16.4)			Commonwealth Government	IT industry health professionals and consumer representatives.
119. Ensuring access to a national broadband network (or alternative technology, such as satellite) for all Australians, particularly for those living in isolated communities, will be critical to the uptake of person-controlled electronic health records as well as to realise potential access to electronic health information and medical advice. (RD 16.5)			Commonwealth Government	NEHTA
120. We recommend that the Commonwealth Government mandate that the payment of public and private benefits for all health and aged care services depend upon the ability to accept and provide data to patients, their authorised carers, and their authorised health providers, in a format that can be integrated into a personal electronic health record, such that: <ul style="list-style-type: none"> hospitals must be able to accept and send key data, such as referral and discharge information ('clinical information transfer'), by 1 July 2012; pathology providers and diagnostic imaging providers must be able to provide key data, such as reports of investigations and supplementary information, by 1 July 2012; 	<p>Legislative changes required</p> <p>Propose legislation to be developed by DoHA in consultation with AHIA in respect of private health benefits.</p>		Commonwealth Government	Commonwealth Government
		HAA		Public and private hospital operators (including states and territories).
		HAA		Pathology providers and diagnostic imaging providers (including states and territories).

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<ul style="list-style-type: none"> other health service providers – including general practitioners, medical and non-medical specialists, pharmacists and other health and aged care providers – must be able to transmit key data, such as referral and discharge information ('clinical information transfer'), prescribed and dispensed medications and synopses of diagnosis and treatment, by 1 January 2013; and all health care providers must be able to accept data from other health care providers by 2013. (RD 16.6) 		HAA		Health service providers, including general practitioners, medical and non-medical specialists, pharmacists and other health and aged care providers (including states and territories).
121. We recommend that the Commonwealth Government takes responsibility for, and accelerate the development of a national policy and open technical standards framework for e-health, and that they secure national agreement to this framework for e-health by 2011-12. These standards should include key requirements such as interoperability, compliance and security. The standards should be developed with the participation and commitment of state governments, the IT vendor industry, health professionals, and consumers and should guide the long-term convergence of local systems into an integrated but evolving national health information system. (RD 16.7)			Commonwealth Government	
122. We recommend that significant funding and resources be made available to extend e-health teaching, training, change management and support to health care practitioners and managers. In addition, initiatives to establish and encourage increased enrolment in nationally recognised tertiary qualifications in health informatics will be critical to successful implementation of the national e-health work program. The commitment to, and adoption of, standards-compliant e-health solutions by health care organisations and providers is key to the emergence of a national health information system and the success of person-controlled electronic health records. (RD 16.8)			Commonwealth Government	NEHTA working with universities and professional colleges, and NCETA.

Recommendations	Comments on implementation	Healthy Australia Accord	Who to lead	Who to do
<p>123. With respect to the broader e-health agenda in Australia, we concur with, and endorse the directions of the National E-Health Strategy Summary (December 2008), and would add that:</p> <ul style="list-style-type: none"> • There is a critical need to strengthen the leadership, governance and level of resources committed by governments to giving effect to the planned National E-Health Action Plan. • This Action Plan must include provision of support to public health organisations and incentives to private providers to augment uptake and successful implementation of compliant e-health systems. It should not require government involvement with designing, buying or operating IT systems. • In accordance with the outcome of the 2020 Summit and our direction to encourage greater patient involvement in their own health care, that governments collaborate to resource a national health knowledge web portal (comprising e-tools for self-help) for the public as well as for providers. The National Health Call Centre Network (healthdirect) may provide the logical platform for delivery of this initiative. • Electronic prescribing and medication management capability should be prioritised and coordinated nationally, perhaps by development of existing applications (such as PBS online), to reduce medication incidents and facilitate consumer amenity (new). 			Commonwealth Government	NEHTA

APPENDIX H: Investing in Reform

The following paper provides information on the financial implications of the recommendations of the Final Report. Recurrent expenditure estimates represent the full year costs for reforms that entail significant additional expenditure or generate significant savings. The estimates are indicative only and further work will be required to refine them. They are intended to give a reasonable idea of the magnitude of the changes in expenditure required to implement our reforms.²³² They do not take account of the improved efficiencies and more appropriate care that will be achieved in the medium to longer term, which separate modelling indicates will result in lower growth in projected expenditure on health and health care over the next two decades.

Changes in government expenditure (Commonwealth and state) have been estimated for those recommendations which we believe are greater than \$10 million per annum.

Even where costs of more than \$10 million are anticipated, some recommendations entail no additional outlays, as governments have already committed funding which can be applied to the reforms we are recommending. For example, there is already a commitment of \$1.58 billion to 'closing the gap' in Aboriginal and Torres Strait Islander people's health and life expectancy. However, even where there is an existing commitment, an amount has been included where the strategies we have proposed differ from, or add to, that existing commitment. An example is the National Health Promotion and Prevention Agency. There is already a commitment to fund a similar body, but we have included an additional \$100 million per year as we have recommended a broader range of functions and activities for such a body.

In general, we have estimated changes in government outlays based on 2008-09 dollars, and in a full year – that is, once a reform has been fully implemented. We have not attempted to estimate the incremental build up of costs over time as reforms are implemented. As it will take several years to implement many of the reforms, the incremental costs in any one year during the implementation period will be much less than the full effect across all of the reforms we propose.

Transformational capital investment to support our reform agenda is also proposed as a critical enabler of a number of key recommendations. Capital can drive change and is fundamental to the efficiencies and reorientation of the health system we are proposing. Short term capital investment will be vital to reshape how care is delivered, fill service gaps, and stimulate change and health service reform now and into the future.

The indicative range of annual costs and savings/productivity gains of the recommendations costed are summarised in Figure 1.

232 Technical notes: Data used in this paper were mostly sourced from publicly available information.

Population projections were based on Australian Bureau of Statistics 'Series C' Population Projections Australia 2006–2101.

Figures for 30 June 2006 are final estimated resident population based on results of the 2006 Census.

Hospital costs were calculated using cost data from the National Hospital Cost Data Collection Cost Report Round 11 (2006–07) produced by the Commonwealth Department of Health and Ageing in conjunction with the States and Territories.

Figure 1: Indicative range of recommendations with material costs or savings

Rec	Reform	Range of costs (savings/revenue)		Comments
		\$m	\$m	
7	Supporting healthy workers			COAG funding noted
9	National Health Promotion and Prevention Agency	100	100	In addition to COAG commitment
16	Cwth responsibility funding & policy primary health care			Transfer funds from States
18	Enrolment of young families, indigenous people, the chronically ill	341	682	
19	PHC prevention, access and quality performance payments	252	800	
21	Primary health care organisations	150	150	Transformed GP Divisions
23,24	Targeted antenatal care & core contacts for child & family health			COAG funding noted
27	Nationals Access Targets and Hospitals/ED	720	1015	Hospital and ED funding
30	National activity-based hospital funding	(1330)	(570)	\$150 m implementation costs
33	National performance reporting & accountability framework	12	12	
38	Enhanced sub-acute care services/aids and equipment	460	460	Capital also required
42	Expanding provision of aged care subsidies	530	838	Note frees up hospital beddays
47	More flexible range of community aged care subsidies	296	437	Note frees up hospital beddays
52	Medical arrangements with residential aged care services	48	48	
57	Advance care planning training			\$6 million implementation costs
59	Aboriginal & Torres Strait Islander health funding			Note COAG commitment
61	National Aboriginal & Torres Strait Islander Health Authority	58	58	
64	Aboriginal & Torres Strait Islander nutrition	12	12	
65	Equivalence funding in remote and rural areas	55	143	
66	Remote & rural outreach, telehealth & advice networks	50	100	
67	Patient travel assistance	85	244	
70	Rural workforce enhancement package	27	27	
71	Communities of youth services	30	30	Core funding, capital also required
72	Early psychosis prevention and intervention services	26	26	COAG funding noted
73	Rapid mental health response team	200	200	COAG funding noted
74	Sub-acute mental health services	70	70	COAG funding noted
77	Employment support for people with mental illness	7	7	COAG funding noted
78	Mental health and dementia support for older Australians	23	23	COAG funding noted
83	Dentcare Australia	3740	3740	Funding for private dental plans
84	Dental residency program	200	200	
85	School dental expansion	100	100	
86	Oral health promotion	20	20	
	Levy to fund 'Dentcare Australia'	(4060)	(4060)	Added to \$1bn in existing direct govt funding
88.9	National health intervention & private hospital regulation	25	25	
99	Reshaping MBS	140	330	Addition to nurse & midwives funding 2009–10
100	New clinical education and training framework			COAG funding noted, capital required
101	National education and training agency			COAG funding noted
102	National professional registration			COAG funding noted
104	Increasing training places in remote & rural areas			COAG capital funding noted
105	Clinical, health services and health policy research	100	100	
109	National health innovation	8	8	
111	Australian Commission for Safety and Quality in Health Care	34	34	
		2529	5409	

Note: This Table includes the costs and savings of all costed recommendations including Dentcare Australia; hence the total cost differs to that of Table 7.2 in the main report.

These indicative estimates do not reflect any interaction between recommendations – each costing is of the proposal in isolation from the others.

We have included estimates of savings which should be realised through funding hospitals based on the efficient costs of delivery. We have not estimated in dollar terms any savings from reductions in use of hospitals that we expect to flow from our recommendations to increase the availability of care that will help people stay out of hospital, or spend less time in hospital. We do expect reductions in use of hospitals for some kinds of care, but we also expect that the capacity freed up by these changes will be taken up by providing more episodes of acute care.

Figure 2 shows estimates of the reductions in hospital patient stays arising from an increase in sub-acute services, improved access to aged care, and advance care planning.

Figure 2: Hospital bed days available for acute care due to other reforms

Hospital bed days made available	'000	'000
Increased sub-acute services	531	531
Improved timely access to aged care	277	555
Advance care planning	256	256
	1064	1341

These should enable 160,000 or more episodes of acute care for people requiring at least an overnight stay in hospital.

Several recommendations also have capital components and these are summarised in Figure 3 below; some of this capital would be funded by applying the first year or two of expected recurrent funding to capital to establish services, the initial capital costs required as part of getting programs up and running are often similar to full year operating costs. For these reasons, the capital costs of new or expanded services cannot simply be added to the proposed recurrent costs, as the latter cannot be incurred until after the initial capital costs have been met.

Figure 3: Capital Investments

Transformation capital investment		\$m	\$m
17	Comprehensive PHC Centres and Services	300	300
38	Investment in sub-acute infrastructure	900	1500
71	Communities of youth health services	30	30
84	Dental training facilities for residency program	375	750
85	School dental service expansion	125	250
97	Clinical education and training facilities across settings	100	150
97	Hospital reshaping	1250	2500
123	ehealth	1185	1865
		4265	7385

RECOMMENDATION 7

We support the delivery of wellness and health promotion programs by employers and private health insurers. Any existing regulatory barriers to increasing the uptake of such programs should be reviewed.

RECOMMENDATION 9

We recommend the establishment of an independent national health promotion and prevention agency. This agency would be responsible for national leadership on the Healthy Australia 2020 goals, as well as building the evidence base, capacity and infrastructure that is required so that prevention becomes the platform of healthy communities and is integrated into all aspects of our health care system.

We recommend that the national health promotion and prevention agency would also collate and disseminate information about the efficacy and cost effectiveness of health promotion including primary, secondary and tertiary prevention interventions and relevant population and public health activities.

Additional annual cost \$100 million

Costing Assumptions COAG has made a commitment to funding of \$797.77 million through the National Partnership Agreement on Preventive Health²³³ and establishing a national preventative health agency tasked with responsibility for providing evidence-based policy advice, overseeing a Commonwealth funded social marketing campaign to extend and complement the Australian Better Health initiative campaign, with states and territories funded to facilitate delivery of healthy living programs in workplaces.

To fulfil the functions we have proposed, the additional cost of national health promotion and prevention is \$100 million including \$30 million for core functions of collating and disseminating information, reporting and publishing wellness footprints, development of evidence based programs for secondary and tertiary prevention, \$30 million for research, surveillance and promotion of prevention activities across the health system and \$40 million for the Healthy Australia Goals development and social marketing. Although COAG has made a commitment to fund the National Health Promotion and Prevention Agency through the National Partnership Agreement on Preventive Health, the level of funding for the Agency is unclear.

233 Council of Australian Governments National Partnership on Preventive Health (2009), At: http://coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_preventive_health.rtf

RECOMMENDATION 16

We recommend that, to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding.

Annual cost	No net costs
Costing Assumptions	Funds transferred from state to Commonwealth for primary health care. 2006–07 community health care and other non-institutional funding not elsewhere classified was \$4,105 million, \$3,637 million was funded by the states ²³⁴ .

RECOMMENDATION 17

We recommend that, in its expanded role, the Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres and Services. We suggest this could be achieved through a range of mechanisms including initial fixed establishment grants on a competitive and targeted basis. By 2015 we should have a comprehensive primary health care system that is underpinned by a national policy and funding framework with services evolving in parallel.

Capital cost	\$300 million – establishment grants
Costing Assumptions	25 per cent population to have access to Comprehensive Primary Health Centres (CPHC) by 2020 (currently only about a million people have access to comprehensive primary care services). On average a centre or service will include 15 full work equivalent GPs able to service a population of 17,190 ²³⁵ . On average a one-off incentive of \$1 million to facilitate the establishment of CPHCs. For comparison, the level of funding for GP super clinics ranged from \$1m to \$12.5m with most between \$2.5m and \$5m. A previous GP practice amalgamation program in the early 2000’s offered payments of \$7500 per FTE practitioner in each eligible amalgamating practice for up to three FTE GPs, plus \$15,000 per eligible practice with a total ceiling payment \$120,000. This program was oversubscribed. However it did not require any non GP involvement and the nature of the amalgamation was much less tightly defined than the creation of the comprehensive centres.

234 Australian Institute of Health and Welfare (2008,)Health expenditure Australia 2006-07, At: <http://www.aihw.gov.au/publications/index.cfm/title/10659>
235 Extrapolated from Department of Health & Ageing (2009), Number of General Practitioners, At: [http://www.health.gov.au/internet/main/publishing.nsf/Content/4F4DB38797665644CA256FFE000C3C7F/\\$File/Table%201.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/4F4DB38797665644CA256FFE000C3C7F/$File/Table%201.pdf)

RECOMMENDATION 18

We recommend that young families, Aboriginal and Torres Islander people and people with chronic and complex conditions (including people with a disability or a long-term mental illness) have the option of enrolling with a single primary health care service to strengthen the continuity, co-ordination and range of multidisciplinary care available to meet their health needs and deliver optimal outcomes. This would be the enrolled family or patient's principal "health care home". To support this, we propose that: there will be grant funding to support multidisciplinary services and care coordination for that service tied to levels of enrolment of young families and people with chronic and complex conditions; there will be payments to reward good performance in outcomes including quality and timeliness of care for the enrolled population and over the longer term, payments will be developed that bundle the cost of packages of primary health care over a course of care or period of time, supplementing fee-based payments for episodic care.

Annual cost \$341–\$682 million depending on the level of enrolment. As enrolment is restricted by both patients' willingness to enrol and services' willingness to participate in the program, \$341m or 50 per cent enrolment is a more likely figure. \$682m implies 100 per cent enrolment.

Costing Assumptions That the number of people eligible to enrol is 32 per cent of the population and includes:

Aboriginal & Torres Strait Islander people ²³⁶	517,000
Children 0–5 years ²³⁷	1,640,000
People with chronic and complex conditions ²³⁸	3,272,700
People with a disability ²³⁹	640,000
People with a mental health problem ²⁴⁰	750,000
TOTAL	6,819,700

It is important to note that, as the number of people who have chronic conditions do not all face complex care needs, the estimated number eligible to enrol includes all those with coronary heart disease, lung and colorectal cancer, 80 per cent with Chronic Obstructive Pulmonary Disease and chronic kidney disease, 50 per cent with depression or osteoporosis, 30 per cent with diabetes or arthritis and 25 per cent of those with asthma. Similarly, for people with a disability we have included half of those with profound or a severe core activity limitation and half of those people with a mental health problem (excluding depression). These estimates include allowance for overlap and co-morbidities.

At around 32 per cent of the population eligible to enrol, if payments were made of \$100 per enrollee, then an average GP would receive enrolment payments of around \$32,500, and an average practice (4.5 practitioners) would receive payments of around \$146,000. This would enable an average size practice to employ 1.5 additional staff.

The cost of payments to reward good performance in outcomes including quality and timeliness of care for the enrolled population has been included in Recommendation 19.

The additional cost of bundling payments for enrolled individuals over a course of care has been assumed to be nil.

236 Australian Institute of Health and Welfare (2008), The health and welfare of Australia's Aboriginal & Torres Strait Islander peoples

237 Australian Bureau of Statistics (2008), Estimated resident population, June 2008

238 Derived from Australian Institute of Health and Welfare, Incidence and prevalence of chronic disease, At: http://www.aihw.gov.au/cdarf/data_pages/incidence_prevalence/index.cfm

239 Australian Bureau of Statistics, People with a disability, At: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features12003?OpenDocument>

240 <http://www.abs.gov.au/ausstats/abs@.nsf/ProductsbyReleaseDate/2D997BB70468E5ADCA2571D900201FB3?OpenDocument>

RECOMMENDATION 19

We recommend embedding a strong focus on quality and health outcomes across all primary health care services. This requires the development of sound patient outcomes data for primary health care. We also want to see the development of performance payments for prevention, timeliness and quality care.

Annual cost \$252–\$800 million

Costing Assumptions The total level of incentive payment will be dependent on the outcome targets which are set, and may to some degree be offset by reductions in ongoing payments such as redirection of indexation and growth.

As an indicator of current outcome payments, the PIP/SIP arrangements which provide incentives for information management, after hours care, practice nurses, quality prescribing, teaching, asthma management, diabetes management, cervical screening and several other factors expends around \$309 m per annum²⁴¹ (about 7 per cent of MBS benefits paid in respect of general practice services).

If the same proportion of the costs of currently state funded primary health care services were added to the system as outcome incentive payments, this would add \$252m to costs.

If the current level of incentives for general practice was to double to 14 per cent to cover a much wider range of conditions and services, and incentive payments for currently state funded services were to be implemented at 7 per cent of current funding levels, the total additional cost would be \$561m.

If the current level of incentives for general practice was to double to 14 per cent to cover a much wider range of conditions and services, and incentive payments for currently state funded services were to be implemented also at 14 per cent of current funding levels, the total additional cost would be \$800m.

RECOMMENDATION 21

Service coordination and population health planning priorities should be enhanced at the local level through the establishment of Primary Health Care Organisations, evolving from or replacing the existing Divisions of General Practice. These organisations will need to have appropriate governance to reflect the diversity of clinicians and services forming comprehensive primary health care; be of an appropriate size to provide efficient and effective coordination (say approx 250,000 to 500,000 population depending on health need, geography and natural catchment) meet required criteria and goals to receive ongoing Commonwealth funding support.

Annual cost \$150 million

Costing Assumptions Divisions received \$157 million in 2004–05²⁴²

To expand the Divisions scope to cover all of primary health care would more than double their potential membership and range of issues. As an indicative cost therefore, \$150m per year may be a start point.

241 DoHA 2008–09 Budget Outcome 5 Program 5.4 Practice Incentives Program (PIP)

242 http://www.mja.com.au/public/issues/187_02_160707/sco10472_fm.html

RECOMMENDATION 23

We recommend beginning the strategy for nurturing a healthy start to life before conception. Universal services would focus on effective health promotion to encourage good nutrition and healthy lifestyles, and on sexual and reproductive health services for young people. Targeted services would include ways to help teenage girls at risk of pregnancy. In the antenatal period, in addition to good universal primary health care, we recommend targeted care for women with special needs or at risk, such as home visits for very young, first-time mothers.

RECOMMENDATION 24

We recommend that universal child and family health services provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring (with contacts weighted towards the first three years of life). The initial contact would be universally offered as a home visit within the first two weeks following the birth. The schedule would include the core services of monitoring of child health, development and wellbeing; early identification of family risk and need; responding to identified needs; health promotion and disease prevention (for example, support for breastfeeding); and support for parenting. Where the universal child and family health services identify a health or developmental issue or support need, the service will provide or identify a pathway for targeted care, such as an enhanced schedule of contacts and referral to allied health and specialist services. Where a child requires more intensive care for a disability or developmental concerns, a care coordinator, associated with a primary health care service, would be available to coordinate the range of services these families often need.

Annual cost

The net additional cost of these recommendations could be nil as COAG has made a commitment to fund the following outcome:

"help assure Australian children of a healthy start to life, including through promoting positive parenting and supportive communities, and with an emphasis on the new-born"

States will receive, through the National Partnership Agreement on Preventive Health, \$326 million over 6 years from 2009-10, half by way of facilitation payments and the balance in the final years for the Healthy Children Program.²⁴³

Costing Assumptions

It has not been possible to cost these recommendations as data is not available on the current level of service provision nor on current costs or on the target population. Services are predominantly state managed and funds are included in community health funding of \$3,637 million expended by states in 2006-07.

243 http://coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_preventive_health.rtf

RECOMMENDATION 27

We recommend development and adoption of National Access Targets for timeliness of care. For example: a national access target for people requiring an acute mental health intervention (measured in hours); a national access target for patients requiring urgent primary health care (measured in hours or days); national access targets for people attending ED (measured in minutes to hours); a national access target for patients requiring coronary artery surgery or cancer treatment (measured in weeks/days); and a national access target for patients requiring other planned surgery or procedures (measured in months). These National Access Targets should be developed incorporating clinical, economic and community perspectives through vehicles like citizen juries and may evolve into National Access Guarantees subject to ensuring there is no distortion in allocation of health resources.

Annual cost: up to \$425m pa for elective surgery NATs (including \$150m to continue current COAG funding beyond 2010–11)
\$295–590m pa for emergency access NATs

Costing assumptions **Elective Surgery NATs**

Preliminary analysis suggests that the additional funding already available through the Elective Surgery Waiting List Reduction Plan could, if extended beyond 2010–11, be sufficient to address excess waiting times.

This assumes:

- existing demand trends continue;
- total outlays on public hospitals continue to grow at recent historical rates;
- addressing bottlenecks allows long wait patients to be treated faster while delaying the treatment of others who nevertheless are treated within targeted timeframes.

However, additional demand created by removal of excess waiting times is estimated to increase demand by up to 50,000 cases. This could cost up to \$275m per annum although this would be reduced if existing cases were delayed within the target.

Emergency Access

The proposed national access target requires all hospitals with a major Emergency Department to maintain an occupancy rate no higher than 85 per cent. While the national average occupancy rate in 2006–07 was 85 per cent, this varied between states (in the range of 76 per cent – 97 per cent with Northern Territory as an outlier at 118 per cent) and could vary more at the individual hospital level.

Assuming that the average reduction in occupancy rate required is 5 percentage points, the number of extra beds required would be 1,776 or 3,552 for a 10 percentage point reduction in occupancy. As this is a buffer of empty beds to be maintained, their average cost, unoccupied, would be low relative to occupied beds.

Assuming that the average cost is \$455 per unoccupied bed-day then the cost of maintaining these beds is about:

\$295m per annum for an average 5 percentage point reduction in occupancy

\$590m per annum for an average 10 percentage point reduction in occupancy.

Some or all of the funding could be made available in the form of bonus payments linked to achievement of the 85 per cent occupancy target at specific hospitals.

RECOMMENDATION 30

We recommend the use of activity-based funding for both public and private hospitals using casemix classifications (including the cost of capital). This approach should be used for inpatient and outpatient treatment. Emergency department services should be funded through a combination of fixed grants (to fund availability) and activity-based funding. For hospitals with a major emergency department service the costs of maintaining bed availability to admit people promptly should be recognised in the funding arrangements.

Annual savings	<p>\$400 million – \$900 million for acute public inpatient services.</p> <p>\$170 million – \$430 million for non-admitted public patient services (savings would be progressively available as implementation progressed)</p>
Offsetting costs	\$150m over 4 years to develop technical infrastructure.
Costing assumptions	<p>The \$400m saving estimate for acute inpatient services assumes that the higher average cost per episode in some states are brought down to the average cost. \$900 million saving assumes all states can match the level of efficiency currently achieved by the most efficient state.</p> <p>The savings estimate for non-admitted patient services is based on the estimate that non-admitted patient services are 30 per cent of total public hospital costs.</p> <p>The implementation cost estimate is sourced from COAG papers.²⁴⁴</p> <p>Savings estimates are based on 2006-07 activity levels and costs.²⁴⁵</p>

Average cost including depreciation

Public Sector by Jurisdiction	Number of weighted separations	Average cost per weighted separation	Average cost per disability adjusted separation
		2006-07	2006-07 ²⁴⁶
NSW	1,427,254	\$3,754	\$3,815
Vic	1,222,040	\$3,514	\$3,721
Qld	751,072	\$3,694	\$3,711
SA	366,929	\$3,575	\$3,747
WA	419,537	\$4,355	\$3,688
Tas	98,948	\$4,209	\$3,530
NT	62,327	\$4,680	\$3,863
ACT	73,703	\$4,285	\$4,053
National	4,422,191	\$3,751	\$3,757

244 http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_hospital_and_health_workforce_reform.pdf

245 [http://www.health.gov.au/internet/main/publishing.nsf/Content/5F8B6BE822DC75B3CA25748300164037/\\$File/R11CostReport_Final.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/5F8B6BE822DC75B3CA25748300164037/$File/R11CostReport_Final.pdf)

246 Based on Commonwealth Grants Commission 2008 updated data

RECOMMENDATION 33

To improve accountability, we recommend that public and private hospitals be required to report publicly on performance against a national set of indicators which measure access, efficiency and quality of care provided.

Annual Cost 12 million

Costing Assumptions The proposed national function estimated funding requirement is based on the current level of Australian government funding of current national health bodies together with their reported operating expenses in 2007–08.

Australian Institute of Health and Welfare currently exists and its funding could be increased to reflect an expanded function of national performance reporting.

RECOMMENDATION 38

We recommend that clear targets to increase provision of sub-acute services be introduced by June 2010. These targets should cover both inpatient and community-based services and should link the demand for sub-acute services to the expected flow of patients from acute services and other settings. Incentive funding under the National Partnership Payments could be used to drive this expansion in sub-acute services.

RECOMMENDATION 41

We recognise the vital role of equipment, aids and other devices, in helping people to improve health functioning and to live as independently as possible in the community. We recommend affordable access to should equipment should be considered under reforms to integrated safety net arrangements.

Annual Cost \$460 million operating costs of expanded sub-acute inpatient and ambulatory services at the same level as Victoria and increased provision of aids and appliances

Costing Assumptions COAG has made a commitment to expand service provision levels by 5 per cent annually from 2009–10 to 2012–13²⁴⁷ with additional Commonwealth funding of \$500 million in 2008–09. Expanding sub-acute service provision by 5 per cent annually until 2012–13 will increase the national average beds per 1,000 older people (70 years and over) from 3 beds²⁴⁸ to 3.6 beds, the number of beds will increase by 1,560 to 8,800.

The proposed bed numbers does not include allocated Transition Care places – these are seen as needed in addition to rehabilitation and Geriatric Evaluation and Management (GEM) beds²⁴⁹.

247 http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_hospital_and_health_workforce_reform.rtf

248 Figure 5.3 National Health and Hospitals Reform Commission Interim Report December 2008

249 National Evaluation of the Transition Care Program

The Australasian Faculty of Rehabilitation Medicine has conservatively estimated that the number of rehabilitation beds alone needs to increase by 43 per cent equivalent to an extra 1 870 rehabilitation beds (from 4,348 beds to 6,218) and that overall the number of rehabilitation and GEM beds required is 45 beds per 100,000 people being 9,500 beds.²⁵⁰

If the number of rehabilitation and GEM beds per 1,000 older people (70 years and over) is increased nationally to the same level as Victoria then the number of beds will increase by a further 1 455 to 10,255 requiring further funding of \$276 million per year.

The annual cost has been calculated at the 2008/09 Victorian rehabilitation bed day rate of \$520²⁵¹ indexed by 3 per cent to reflect depreciation. Compensable revenue such as workers compensation insurance and motor vehicle third party insurance has not been offset against the cost as it is unlikely to increase with additional sub-acute beds. The annual cost does not include Transition Care expenditure.

The annual cost also includes a 10 per cent increase in direct Commonwealth outlays for aids and appliances which was \$298 million in 2006–07 (or \$29.8 million).

The annual cost of providing sub-acute ambulatory care to the level of Victoria would be \$307 million based on funding at Victoria's 2007-08 level of \$169 per person aged 70 years and over. If we assume that the existing level of ambulatory provision in states and territories other than Victoria is half the Victorian level, then the additional cost of bringing all states and territories up to the Victorian level would be \$154 million.

In total, the costs are \$276 million for sub-acute inpatient services, \$29.8 million for aids and equipment and \$154 million for sub-acute ambulatory services, equalling \$460 million.

250 Australasian Faculty of Rehabilitation Medicine (2008) Submission 21 to the National Health and Hospitals Reform Commission

251 <http://www.health.vic.gov.au/pfg/pfg0809/pfg0809.pdf>

RECOMMENDATION 42

We recommend that government subsidies for aged care should be more directly linked to people rather than places. As a better reflection of population need, we recommend the planning ratio transition from the current basis of places per 1000 people aged 70 or over to care recipients per 1000 people aged 85 or over.

Annual cost

	additional places resulting from new 85+ ratio of 620 places/1000	additional cost resulting from new 85+ ratio of 620 places/1000
June 2011	16368	\$530,171,127
June 2012	20450	\$662,398,152
June 2013	24453	\$792,073,110
June 2014	25831	\$836,684,503
June 2015	26711	\$865,195,420
June 2016	25892	\$838,683,004
June 2017	18705	\$605,891,725
June 2018	12608	\$408,383,382
June 2019	6940	\$224,788,818
June 2020	1468	\$47,546,484

Costing assumptions That the ratio of places which is targeted to be 113 places per 1000 people aged 70 and over by 2011 will change to 620 care recipients per 1000 people aged 85 or over²⁵².

The annual cost is additional to the cost of maintaining the ratio at 113 places per 1000 people aged 70 or over.

The mix of residential and community care subsidies will remain as is, that is

- Residential high care 39 per cent
(target of 44 places out of 113)
- Residential low care 39 per cent
(target of 44 places out of 113)
- Community aged care 19 per cent
(target 21 packages out of 113)
- EACH packages 3 per cent
(target 4 packages out of 113)²⁵³.

The average cost of residential care is \$37,900.

The average cost of community & EACH care is \$13,000.

252 [http://www.ausstats.abs.gov.au/ausstats/abs@archive.nsf/0/E4B1AAE2BF6356A1CA2574B90016BCC3/\\$File/32220c9.xls](http://www.ausstats.abs.gov.au/ausstats/abs@archive.nsf/0/E4B1AAE2BF6356A1CA2574B90016BCC3/$File/32220c9.xls)

253 <http://www.aihw.gov.au/publications/age/raca06-07/raca06-07.pdf>

The total number of aged care places in June 2007 equated to 620 places per 1000 people aged 85 and over.

Changing the target of provision of aged care subsidies to 620 care recipients per 1000 people aged 85 or over requires an increase of 6 per cent or \$580 million per annum on average over 10 years above the funding required to maintain the 2011 target of 113 places per 1000 people aged 70 or more years.

There will be a resulting reduction in hospital stays with savings of 277,000 to 547,000 bed days²⁵⁴.

RECOMMENDATION 47

We recommend that there be a more flexible range of care subsidies for people receiving community care packages, determined in a way that is compatible with care subsidies for residential care.

Annual cost \$296m – \$437 million

Costing Assumptions These indicative costs use a baseline of 46,300 community places, of which 2000 are Extended Aged Care at Home – Dementia (EACH-D) places and 4300 are Extended Aged Care at Home (EACH) places, with the remaining 40,000 being Community Aged Care Packages (CACP). This approximates the allocation of community care places in mid-2008.

The Aged Care Funding Instrument used in residential aged care provides many different levels of funding according to basic care needs, complex health care needs and challenging behaviour. Lacking any data as to the likely distribution of these characteristics for people receiving community care, we have taken a simpler approach.

For both the high and the low range estimates we have assumed that the baseline numbers of EACH and EACH-D recipients remain unchanged, and that the levels of care subsidy would be the same as currently apply, at \$42,398 pa and \$46,760 pa respectively.

For the high range estimate, we assumed that the lowest level of subsidy would be the same as for a CACP now – \$12,683 pa, and the two highest levels would be the same as currently apply for EACH and EACH-D packages, \$42,398 pa and \$46,760 pa respectively. Five new intermediate levels of community care would have increasing levels of subsidy evenly spread from \$17,636 pa to \$37,446 pa.

For the high range estimate, we assumed that 40,000 recipients of community care other than EACH and EACH-D would decline linearly from 8357 receiving the lowest level of subsidy to 5000 receiving the highest level below an EACH package.

For the low range estimate, we have assumed that the lowest level of subsidy would be less than for a CACP now, or \$10,000 pa, with more people on the lower levels of care subsidy, and many fewer on the higher of the new levels.

254 DoHA survey

Our assumption of a diminishing number of people in the higher levels takes into account the level of informal care that people generally require to remain at home. As people's dependency levels increase, fewer have carers who are able to support them at home even with higher levels of subsidised care. In the lower cost scenario, our assumption that the lowest level of care subsidy would be lower than a current CACP, takes into account that some people receive less than average levels of care under current CACPs and some receive more.

Baseline				high range estimate			low range estimate		
	recipients	subsidy (\$pa)	\$m	recipients	subsidy (\$pa)	\$m	recipients	subsidy (\$pa)	\$m
CACP	40,000	12,683	507	8,357	12,683	106	12,222	10,000	122
				7,681	17,636	135	7,996	15,400	123
				7,005	22,588	158	5,916	20,799	123
				6,329	27,541	174	4,953	26,199	130
				5,652	32,493	184	4,538	31,599	143
				4,976	37,446	186	4,376	36,999	162
EACH	4,300	42,398	182	4,300	42,398	182	4,300	42,398	182
EACH-D	2,000	46,760	94	2,000	46,760	94	2,000	46,760	94
	46,300		783	46,300	239,545	1,220	46,301	230,155	1,079
				Additional expenditure		437	Additional expenditure		296

RECOMMENDATION 52

We recommend that funding be provided for use by residential aged care providers to make arrangements with primary health care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes.

Annual cost

\$48 million being \$172 million cost of contracting GPs less offset of reduction in MBS rebates of \$124 million

Costing Assumptions

As at 30 June 2007 there were 153,426 permanent residents in 2872 mainstream residential aged care services in Australia. On average there were 58 places per service.²⁵⁵

71 per cent of residents are female and 54 per cent of residents are aged 85 years and over. On average this age group of women visit their GP over 10 times per year but men visit less frequently.²⁵⁶

That the annual cost of contracting a GP (or other health professionals with appropriate competencies) to provide on average 30 minutes consultation per permanent resident per month is \$60,000 for an average sized aged care home with just under 60 residents (based upon the NSW sessional rate for GPs²⁵⁷, with an average of 2 sessions of 3 hours per week per aged care home).

There may be some offsetting reductions in MBS rebates if there is no increase in GP workforce and overall GP activity remains constant (a GP's available practice consulting time would be reduced by about 6 hours per week whilst providing residential aged care services). The offsetting reduction in MBS

255 <http://www.aihw.gov.au/publications/age/raca06-07/raca06-07.pdf>

256 <http://www.aihw.gov.au/publications/age/oag04/oag04-c00.pdf>

257 http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_032.pdf

rebates has been estimated at \$124 million based on a reduction of 24 Item 23 Level B²⁵⁸ consults per week per participating GP. There is probably little offsetting reduction in MBS diagnostic rebates as the level of pathology and radiology tests would remain at a similar level.

RECOMMENDATION 57

We recommend that advance care planning be funded and implemented nationally commencing with all residential aged care services, and then being extended to other relevant groups in the population. This will require a national approach to education and training of health professionals including greater awareness and education among health professionals of the common law right of people to make decisions on their medical treatment, and their right to decline treatment. We note that, in some states and territories, this is complemented by supporting legislation that relates more specifically to end of life and advance care planning decisions.

Annual Cost

Ongoing costs will be minimal but there will be implementation costs of \$6 million over 4 years for training staff in residential aged care services and other relevant groups.

Annual Savings

As highlighted in the Interim Report, it is envisaged that there will be a resulting substantial reduction in hospital admissions and length of stay with savings of 256,000 bed days.

Costing Assumptions

Implementation costs are based on the cost of the oral and dental plan for nursing homes announced March 2009.

In 2006–07, 44,271 permanent aged care residents died.

The reduction in hospital admissions and length of stay is based on research undertaken at Austin Health where residents in aged care facilities who had been introduced to the Respecting Patient Choices program had an 18 per cent chance of hospital admission with an average length of stay of 6.9 days and residents in aged care facilities who had **not** been introduced to the respecting Patient Choices program had a 46 per cent chance of hospital admission with an average length of stay of 15.3 days prior to dying²⁵⁹.

RECOMMENDATION 59

We recommend an investment strategy for Aboriginal and Torres Strait Islander people's health that is proportionate to health need, the cost of service delivery, and the achievement of desired outcomes. This requires a substantial increase on current expenditure.

Additional Cost

The net additional cost of this is proposed to be zero, as COAG has agreed to funding of \$1.58 billion over the four years 2009-10 to 2012-13. Accordingly the Commission's recommendation does not entail additional expenditure above what would be required by the existing commitment apart from the additional cost for the operations of the National Aboriginal and Torres Strait Islander Health Authority (Recommendation 61) and additional funding for good nutrition and a healthy diet (Recommendation 64). Any additional costs arising from building the organisational capacity of Community Controlled Health Services (Recommendation 60) would be funded from the existing commitment.

258 <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q1=NotelD&q=A5>

259 Austin Health (2008) Submission 534 to NHHRC

RECOMMENDATION 61

Acknowledging that significant additional funding in Aboriginal and Torres Strait Islander health care will be required to close the gap, we recommend that a dedicated, expert commissioning group be established to lead this investment. This could be achieved by the establishment of a National Aboriginal and Torres Strait Islander Health Authority within the Health portfolio to commission and broker services specifically for Aboriginal and Torres Strait Islander people and their families as a mechanism to focus on health outcomes and ensure high quality and timely access to culturally appropriate care.

Annual cost \$58 million

Costing Assumptions The cost is based on the 2007–08 costs of administering the DVA health services for repat card holders of \$ 96.9 million offset by the funding in 2008–09 of OATSI²⁶⁰ program management of \$38.5 million (net cost of \$58.4 million). As at June 2008 there were 294,977 repat card holders, the cost of DVA arrangements for delivery of health and other care services during 2007–08 was \$74.9 million plus allocated overheads of \$21.9 million (totalling \$96.9 million). DVA administers about \$4.7 billion in health services expenditure. Although the Aboriginal and Torres Strait Islander population is greater than the number of repat card holders, a similar sized organisation to DVA is envisaged given the different nature of tasks.

RECOMMENDATION 64

We support the delivery of wellness an Good nutrition and a healthy diet are key elements of a healthy start to life. But many Aboriginal and Torres Strait Islander people living in remote areas have limited access to affordable healthy foods. We recommend an integrated package to improve the affordability of fresh food – particularly fruit and vegetables – in these targeted remote communities. This package would include subsidies to bring the price of fresh food in line with large urban and regional centres, investment in nutrition education and community projects, and food and nutrient supplementation for schoolchildren, infants, and pregnant and breastfeeding women. The strategy would be developed in consultation with these Aboriginal and Torres Strait Islander communities, building on some of the successful work already underway. There would be an evaluation to assess the benefits of extending the program to other communities, focusing on the changes to eating habits and improvements to health. d health promotion programs by employers and private health insurers. Any existing regulatory barriers to increasing the uptake of such programs should be reviewed.

Annual cost \$12 million

Costing Assumptions A notional amount has been included as information is not available to accurately cost this proposal.

260 [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009_Health_PBS/\\$File/Outcome%208.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009_Health_PBS/$File/Outcome%208.pdf)

RECOMMENDATION 65

Flexible funding arrangements are required to reconfigure health service delivery to achieve the best outcomes for the community. To facilitate locally designed and flexible models of care in remote and small rural communities, we recommend: funding equivalent to national average medical benefits and primary health care service funding, appropriately adjusted for remoteness and health status, be made available for local service provision where populations are otherwise under-served; and expansion of the multi-purpose service model to towns with catchment populations of approximately 12,000.

Annual cost

\$55 million – \$143 million depending on whether this reform applies to rural as well as remote-rural and remote populations and GP-only primary health care

Costing Assumptions

The annual cost of funding equivalent to national average medical benefits has been based on increasing the level of funding for people in rural, remote-rural and remote communities to the national average benefit per person Australia wide of all Medicare rebates processed for GP services 2007-08 only.

The cost excludes funding for the Aboriginal and Torres Strait Islander population as their health needs will be funded as per Recommendation 59.

The Rural Remote Metropolitan Area (RRMA) classification system has been used as amended by the Primary Health Care Research and Information Service.²⁶¹

Remote Divisions of General Practice included NSW Outback, Kimberley, Goldfields Esperance, Pilbara and Central Australia (now part of NT SBO).

Rural-remote Divisions of General Practice included Murrumbidgee, East Gippsland, Mallee, Central Queensland Rural, Mackay, Rheath, North & West Qld Primary Health Care, Far North Queensland Rural, Eyre Peninsula, Flinders and Far North, Great Southern GP Network, Mid West and Wheatbelt GP Network.

Rural Divisions of General Practice included Shoalhaven, Hastings Macleay, Mid North Coast, Northern Rivers, New England, Riverina, NSW Central West, Dubbo Plains, Barwon, North West Slopes (NSW), North East Victorian, Central West Gippsland, Otway, Ballarat & District, Central Victoria, Goulburn Valley, Albury Wodonga Regional, West Victoria, Murray Plains, GP Connections, General Practice Cairns, Sunshine Coast, Capricornia, Wide Bay, Barossa, Yorke Peninsula, Mid North, Riverland, Limestone Coast, Murray Mallee, GP Down South, Greater Bunbury, General Practice North (Tas) and General Practice North West

The average \$ Benefit per person all Medicare rebates processed for GP services 2007–08²⁶² were

	\$ Benefit per person
Remote	\$120
Rural-remote	\$178
Rural	\$200
Total Australia	\$218

²⁶¹ <http://www.phcris.org.au/fastfacts/fact.php?id=4801>

²⁶² Extrapolated from Div GP All Medicare by MBS category

Due to data constraints it has not been possible to determine the level of other state and Commonwealth primary health care expenditure that applies to rural and remote communities. It has not been possible to determine which communities receive total primary care funding at a level similar to metropolitan areas and which are otherwise underserved. The Commonwealth alone has more than 60 programs²⁶³ funding rural health initiatives, including the following:

	\$m
PIP Rural Loading ²⁶⁴	27
PIP Rural Practice nurse incentive ²⁶⁵	23
More Allied Health Services ²⁶⁶	14.9
Royal Flying Doctor Service ²⁶⁷	70
Regional Health Services ²⁶⁸	28.3
Total	163.2

Costs have not been indexed to reflect the effect of geographic location as it has proven difficult to estimate the total effect of geographic location. The major factors explaining variability in costs between practices are identified below:

Effect of geographic location on cost categories²⁶⁹

Resource category	Major effect of geographic location
Wages and staff costs	Reception staff salary levels do not vary greatly across Australia. Higher levels are recorded in Sydney and Melbourne.
Occupancy costs	Location of practice in a hospital or medical precinct is the greatest determinant of rent variation. In the same location, rents are highest in Sydney and Melbourne with lower rents in Hobart. Rurality affects rent favourably but availability of suitable accommodation may negate this.
Office expenses	No great variation between states but can increase with rurality.
Professional costs	Higher cost of travel for CME in some areas but this is often offset by subsidies in remote areas.
Motor vehicle expenses	Higher cost of fuel in some states and areas. Higher cost of insurance in Sydney and Melbourne. Difficult to estimate the total effect.
Professional indemnity	Clear state differentials.
Working capital expenses	No substantial differences across states or locations. Recent Regional Prices Indices prepared for Western Australia ²⁷⁰ and Queensland have highlighted the significant impact that mining can have on remote communities particularly with the costs of housing. The least expensive regions compared with Brisbane were found in regional Queensland. ²⁷¹ The remote areas of Pilbara, Kimberley and Goldfields-Esperance have significantly higher commodity prices greater than Perth.

263 [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009_Health_PBS/\\$File/Outcome%206.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009_Health_PBS/$File/Outcome%206.pdf)

264 DoHA 2007-08 expenditure unpublished data

265 DoHA 2007-08 expenditure unpublished data

266 DoHA 2003-04 Budget as forecast 2000-01

267 RFDS 2007-08 Finance Statements

268 DoHA 2003-04 Budget as forecast 2000-01

269 PricewaterhouseCoopers 2000 Medicare Schedule Review

270 <http://www.dlgrd.wa.gov.au/Publications/Docs/RegionalPriceIndex2007.pdf>

271 <http://www.oesr.qld.gov.au/queensland-by-theme/economic-performance/prices/regular-publications/index-retail-prices-reg-centres/index-retail-prices-reg-centres-200605.pdf>

RECOMMENDATION 66

Care for people in remote and rural locations necessarily involves bringing care to the person or the person to the care. To achieve this we recommend: networks of primary health care services, including Aboriginal and Torres Strait Islander Community Controlled Services, within naturally defined regions; expansion of specialist outreach services – for example, medical specialists, midwives, allied health, pharmacy and dental/oral health services; telehealth services including practitioner-to-practitioner consultations, practitioner-to-specialist consultations, teleradiology and other specialties and services; referral and advice networks for remote and rural practitioners that support and improve the quality of care, such as maternity care, chronic and complex disease care planning and review, chronic wound management, and palliative care; and 'on-call' 24-hour telephone and internet consultations and advice, and retrieval services for urgent consultations staffed by remote medical practitioners. Further, we recommend that funding mechanisms be developed to support all these elements.

Additional cost \$50–\$100 million

Costing assumptions We have not had the opportunity to estimate the cost of the many different initiatives contained within this recommendation. To ensure that some allowance is made for the cost of these reforms we have allocated a notional range of \$50–\$100 million in a full year.

RECOMMENDATION 67

We recommend that a patient travel and accommodation assistance scheme be funded at a level that takes better account of the out-of-pocket costs of patients and their families and facilitates timely treatment and care.

Additional cost \$85 million (at current levels of demand) – \$244 million (at 2.25 times current demand)

Costing assumptions The cost of a nationally consistent Patient Travel Assistance Scheme (PTAS) has been based on research undertaken by PricewaterhouseCoopers in 2008²⁷² which features:

- subsidy of \$100 per night for both commercial and private accommodation with escorts eligible for 50 per cent of accommodation subsidy,
- rebate of 25 cents per kilometre for road travel,
- no co-payments for concession card holders,
- co-payment of first night's accommodation (\$100) or first 100 km (\$25) for day trip for non-concession card holder.

Current expenditure was based on state and territory submissions to the Senate Enquiry²⁷³ as well as Departments of Health Annual reports and detailed Patient Travel Assistance Scheme (PTAS) data from Queensland Health. Northern Territory, ACT and Tasmanian data was insufficient to undertake a full analysis so the average increase from the other states (Queensland, Western Australia, New South Wales, Victoria and South Australia) was extrapolated to estimate the potential cost of the scheme across Australia.

272 PriceWaterhouseCoopers, 2008 High level cost of a National Patient Travel Assistance Scheme unpublished

273 The Senate Standing Committee on Community Affairs: Highway to health: better access for rural, regional and remote patients

RECOMMENDATION 70

We recommend that the Clinical Education and Training Agency take the lead in developing an integrated package of strategies to improve the distribution of the health workforce. This package could include strategies such as providing university fee relief, periodic study leave, locum support, expansion of medical bonded scholarships and extension of the model to all health professions; preferential access for remote and rural practitioners to training provided by specialty colleges recognising related prior learning and clinical experience and/or work opportunities for practitioners returning to the city and support for those who plan to return again to remote or rural practice once specialty attained.

Annual cost \$27 million

Costing Assumptions We have not had the opportunity to estimate the cost of the many different initiatives contained within this recommendation. The indicative cost shown is a doubling of the 2009–10 Budget allocation of \$26.7 million to expand the scope of incentives for rural general practitioners, as extending these to other rural health professionals would at least double the potential target population.

RECOMMENDATION 71

We recommend that a patient travel and accommodation assistance scheme be funded at a level that takes better a We recommend that a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service. ccount of the out-of-pocket costs of patients and their families and facilitates timely treatment and care.

Annual cost \$30 million
\$30 million capital

Costing Assumptions 30 Communities of Youth Services in all states and territories have been established by way of grant funds averaging \$950,000 through *headspace*²⁷⁴. Expanding the program by establishing another 30 communities would cost \$30 million in capital and \$30 million in ongoing funding.

Communities of Youth Services are currently funded through a mix of MBS, PBS and grant funds. Each community requires about \$500,000 per year operating funds.

Ongoing funding for the communities may be included in the recent announcement²⁷⁵ of continued funding of *headspace* of \$35.6 m over 3 years from July 2009 once *headspace* had repositioned itself as independent company

Some *headspace*, such as *headspace Goldcoast* are already promoting access to sexual health advice from their GPs.

274 http://www.headspace.org.au/_uploads/documents/Microsoft%20Word%20-%202008%20YSDF%20plain%20language%20summary%20of%20grants_Final%20_3_.pdf
275 http://www.headspace.org.au/_uploads/documents/2008%20media%20releases/MediaRelease121208MinsterRoxon.pdf

RECOMMENDATION 72

We recommend that the Early Psychosis Prevention and Intervention Centre model be implemented nationally so that early intervention in psychosis becomes the norm.

Annual cost	\$26 million net of estimated Victorian YEP program
Costing Assumptions	<p>The Victorian Youth Early Psychosis (YEP) program is targeted at young people aged between 16 and 25.</p> <p>There were 695,000 Victorians aged between 16 and 25 in June 2008 and nationally there were 2.836 million.</p> <p>Dedicated funding for new regional YEP services totalled \$5.5 million²⁷⁶ in 2006–07 in addition to EPPIC CCT and EPPIC state-wide with total funding estimated at \$8.5 million. The service is funded as part of COAG National Action Plan for Mental Health 2006-2011.²⁷⁷</p> <p>The cost of implementing the YEP service nationally has been based on the Victorian funding per youth of \$12. This may over estimate the cost as it has not been possible to determine if other states include similar services in their early intervention services for young people.</p>

RECOMMENDATION 73

We recommend that every acute mental health service have a rapid-response outreach team for those individuals experiencing psychosis, and subsequently have the acute service capacity to provide appropriate treatment.

Annual cost	\$200 million
Costing Assumptions	It has not been possible to cost this recommendation as data is not readily available on the current level of service provision. However the Mental Health Council of Australia has estimated the expenditure required for designated teams to provide in-home acute care at \$200 million per year. ²⁷⁸

RECOMMENDATION 74

We recommend that every hospital-based mental health service should be linked with a multi-disciplinary community-based sub-acute service that supports 'stepped' prevention and recovery care.

Annual cost	\$70 million
Costing Assumptions	It has not been possible to cost this recommendation as data is not readily available on the current level of service provision however the Mental Health Council of Australia has estimated the expenditure required for step up/step down accommodation options at \$70 million per year. ²⁷⁹

276 <http://www.health.vic.gov.au/mentalhealth/psychosis/yep-report-07.pdf>

277 http://coag.gov.au/reports/docs/AHMC_COAG_mental_health.doc

278 Mental Health Council of Australia (2006) Time for service

279 Mental Health Council of Australia (2006) Time for service

RECOMMENDATION 77

We want governments to increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support.

Annual cost \$7 million

Costing Assumptions The Australian Government has committed to funding of \$39.8 million to help people with a mental illness enter and remain in employment as part of COAG National Action Plan for Mental Health 2006–2011.²⁸⁰

Doubling the annual 2006–07 allocation of \$6.51 million would significantly increase the investment in vocational rehabilitation and post-placement employment support.

RECOMMENDATION 78

As a matter of some urgency, governments must collaborate to develop a strategy for ensuring that older Australians, including those residing in aged care facilities, have adequate access to specialty mental health and dementia care services.

Annual cost \$23 million

Costing Assumptions The New South Wales Government has committed to funding of \$37.3 million for specialist assessment of the needs of older people as part of COAG National Action Plan for Mental Health 2006–2011.²⁸¹

The cost of implementing this recommendation has been based on the full year funding of the New South Wales service across the 2008 population aged 80 years and over.

RECOMMENDATION 83

We recommend that all Australians should have universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay. This should occur through the establishment of the 'Denticare Australia' scheme. Under the 'Denticare Australia' scheme people will be able to select between private or public dental health plans. 'Denticare Australia' would meet the costs in both cases. The additional costs of Denticare could be funded by an increase in the Medicare Levy of 0.75 per cent of taxable income.

Additional cost The net additional cost to government of funding this recommendation is nil, if the government chooses to implement the proposed increase in the Medicare Levy. The total annual cost of dental services within scope is \$5.5bn (including \$200m for dental residency program, \$100m school dental expansion and \$20m oral health promotion), of which the government would meet \$4.9bn. Existing direct government funding of dental services is about \$1 billion. The additional cost to government of the scheme is therefore \$3.9bn, which could be fully funded by a 0.75 per cent levy of taxable income, with a small additional amount for growth of private dental of about 5 per cent.

280 http://coag.gov.au/reports/docs/AHMC_COAG_mental_health.doc

281 http://coag.gov.au/reports/docs/AHMC_COAG_mental_health.doc

Costing Assumptions	<p>The scope of dental services to be covered by the Scheme includes restorative, preventative, diagnostic services and extractions, dentures and existing public dental services.</p> <p>The scheme will fund 100 per cent of the cost of services within scope delivered by public dental practitioners and 85 per cent of those delivered by private dental practitioners.</p> <p>The estimate of the total annual cost of the scheme is based on 2005–06 expenditure on dental care adjusted for the medical threshold tax rebate, Commonwealth dental plan and teen Dental Plan, updated with 2006–07 data and estimates of population growth, population ageing and increases in dental visits and services arising from higher income to provide a 2008–09 baseline.²⁸²</p> <p>Existing direct government funding of dental services is about \$1 billion.</p> <p>It is assumed that all those that currently use private dental practitioners will opt for a private plan under Denticare.</p> <p>There is scope for limited expansion (about 5 per cent) in the supply of private dental services early in the scheme and public dental services increase by about 50 per cent, if a levy set at 0.75 per cent of taxable income is used to fund the scheme (equivalent to funding of \$4.1 billion).</p> <p>In addition no savings have been factored into the costing due to a reduction in the current proportion of private health insurance (PHI) rebates that are attributable to insurance for dental care (approx \$470 million pa). In practice, as many of the dental costs met currently through private health insurance would be covered by Denticare Australia, it is reasonable to suppose that people's expenditure on premiums for private dental cover would reduce, with a proportionate saving to government outlays on PHI rebates. These reductions in PHI rebates could also be applied to growth in services under Denticare of more than 5 per cent, at no net additional cost to government.</p>
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RECOMMENDATION 84

We recommend the introduction of a one-year internship scheme prior to full registration, so that clinical preparation of oral health practitioners (dentists, dental therapists and dental hygienists) operates under a similar model to medical practitioners. This will require an investment in training and capital infrastructure.

Additional cost	<p>\$200 million operating costs</p> <p>\$150 million capital costs per year for 5 years</p>
Costing Assumptions	<p>In order to build the capacity of the hubs (i.e. dental teaching hospitals) a new hub would be required each year for five years. The spokes, or academic oral health service centres, barely exist at present. Some 10 such centres would need to be established each year for five years to build the capacity toward the 700 graduate residents. These developments would require some \$150 million p.a. The full operating cost of the residency program would be of the order of \$200 million p.a. About half this cost is for residents' salaries and the remainder for appropriate support for the residency program and their service provision.^{283,284}</p>

282 Price Waterhouse Coopers 2008, Costing a Social Insurance Scheme for Dental Care

283 John Spencer Discussion Paper for NHRC 2008, Improving Oral Health and Dental Care for Australians

284 Price Waterhouse Coopers 2008, Costing a Social Insurance Scheme for Dental Care

RECOMMENDATION 85

We recommend the national expansion of the pre-school and school dental programs.

Additional cost \$100 million
 \$50 million capital costs per year for 5 years

Costing Assumptions A revitalization of the school dental services could be partially accommodated within the proposed dental residency program, but would require additional funds to build specific infrastructure, for instance linked to the emerging super schools and new oral health service centres, and to an expansion of the numbers of dental therapists employed. Existing infrastructure is also ageing and a revitalization and extension of the school dental services infrastructure might require a total of \$50 million p.a. for five years. It is estimated that the school dental services have a recurrent cost of approximately \$100 million p.a. A 100 per cent expansion of their coverage of primary and secondary school children would require \$100 million total from all levels of government.^{285,286}

RECOMMENDATION 86

We recommend that additional funding be made available for improved oral health promotion, with interventions to be decided based upon relative cost-effectiveness assessment.

Additional cost \$20 million

Costing Assumptions The cost of stimulating oral health promotion activities would be modest. A recurrent expenditure of some \$20 million p.a. would dramatically increase the levels of integration of oral health into general health promotion and specific oral health promotion activities.^{287,288}

RECOMMENDATION 88.9

The Commonwealth, state and territory governments would agree to establish national approaches to health workforce planning and education, professional registration, patient safety and quality (including service accreditation), e-health, performance reporting (including the provision of publicly available data on the performance of all aspects of the health system), prevention and health promotion, private hospital regulation and health intervention and technology assessment.

Annual cost \$25 million in addition to the national functions costed in other recommendations

285 Draws on John Spencer Discussion Paper for NHHRC 2008, Improving Oral Health and Dental Care for Australians
286 Price Waterhouse Coopers 2008, Costing a Social Insurance Scheme for Dental Care
287 Draws on John Spencer Discussion Paper for NHHRC 2008, Improving Oral Health and Dental Care for Australians
288 Price Waterhouse Coopers 2008, Costing a Social Insurance Scheme for Dental Care

Costing Assumptions

Proposed national functions		Estimated annual cost
#		\$'000
111	National Safety & Quality in Health Care	34000
9	National Health Promotion and Prevention	100000
	National Health Intervention Assessment	20000
	National Private Hospital Regulation	5000
109	National Health Innovation	8000
33	National Performance Reporting and Accountability Framework	12000
61	National Aboriginal and Torres Strait Islander Health Authority	58368
		<hr/> 237368

National safety and quality in health care is detailed in Recommendation 111, **national health promotion and prevention** in Recommendation 9, **national health innovation** in Recommendation 109, **national performance reporting and accountability** in recommendation 33 and **National Aboriginal and Torres Strait Islander Health Authority** in recommendation 61.

The proposed national functions estimated funding requirements are based on the current level of Commonwealth government funding of current national health bodies together with their reported operating expenses in 2007-08^{289,290}.

The net additional cost of national **registration of health professionals** is proposed to be zero as government is already committed to funding this.

The net additional cost of national **clinical education and training** is proposed to be zero as COAG has made a commitment to fund this.

A number of national bodies currently exist and their funding could be increased to reflect their expanded functions such as MSAC and PBAC and national **health intervention assessment**, National Institute of Clinical Studies (now part of NHMRC) and **national health innovation**, Australian Institute of Health and Welfare and **national performance reporting**.

Other functions such as **national private hospital regulation** costs could well be offset by a transfer of state funding as regulation is now done on a state by state basis.

289 http://www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009_Health_PBS

290 <http://www.dva.gov.au/media/aboutus/annrep08/pdf/outcome2.pdf>

RECOMMENDATION 97

Additional capital investment will be required on a transitional basis to facilitate our recommendations. In particular, we recommend that: priority areas for new capital investment should include: the establishment of Comprehensive Primary Health Care Centres and Services; an expansion of sub-acute services including both inpatient and community-based services; investments to support expansion of clinical education across clinical service settings; and targeted investments in public hospitals to support reshaping of roles and functions, clinical process redesign and a reorientation towards community-based care; and capital can be raised through both government and private financing options. The ongoing cost of capital should be factored into all service payments.

Capital cost \$1350–\$2650 million (in addition to capital requirements costed in other recommendations)

Costing Assumptions

17.	Comprehensive Primary Health Care Centres	\$300m
38.	Sub-acute infrastructure expansion	\$900–\$1500m
71.	Communities of youth health services	\$30m
84.	Dental training facilities for residency	\$375–\$750m
85.	School dental service expansion	\$125–\$250m

The following two initiatives have not been costed in other recommendations and are included in this section.

Clinical education and training facilities expansion	\$100–\$150m
Hospitals to be used for reshaping of roles and functions and clinical process redesign with a particular emphasis on dedicated elective surgical units and emergency department efficiency.	\$1250–\$2500m

Identified Government capital expenditure has historically varied little as a percentage of recurrent health expenditure and averaged 7.9 per cent for public acute hospitals for the decade ended 1999–2000.²⁹¹

Redevelopment of hospitals has been based on 30-90 per cent of the cost of an equivalent new hospital, dependent on age and quality of the building stock, services and other infrastructure.²⁹²

291 John Deeble 2000 Capital investment in public hospitals
292 Department of Health Vic Hospital Capital Planning

RECOMMENDATION 99

To improve access to care and reflect current and evolving clinical practice we recommend that: Medicare rebates should apply to relevant diagnostic services and specialist medical services ordered or referred by nurse practitioners and other health professionals having regard to defined scopes of practice determined by recognised health professional certification bodies. Pharmaceutical Benefits Scheme subsidies (or, where more appropriate, support for access to subsidised pharmaceuticals under section 100 of the National Health Act 1953) should apply to pharmaceuticals prescribed from approved formularies by nurse practitioners and other registered health professionals according to defined scopes of practice. Where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialled for defined scopes of practice.

Annual cost

\$140–\$330 million in addition to \$22.5 million allocated to fund the expansion of MBS and PBS to nurse practitioners and midwives in 2010–11

Costing Assumptions

This assumes a constant number of practice nurse services, plus practice nurses would not prescribe (as they are in a GP practice, and if they did prescribe it would be on behalf of the GP).

The limit of 12 psychological therapy services would be retained so there would be no net change in the number of psychological services.

The number of other allied health services provided under a GP EPC plan or some other arrangement but using similarly priced MBS items would double.

Psychologists and other allied health services would prescribe and order tests in addition to the GP ordering, at 25 per cent of the rate at which GPs order²⁹³.

As most specialist are fully engaged, it is assumed that the capacity of health professionals other than doctors to refer to specialists will improve efficiency, and may enable some patients to attend specialists who would not otherwise have done so, but would not add to costs but simply shift waiting times.

Access to MBS benefits for procedures by providers other than nurses will be small. For nurses however this is more difficult, and depends on their scopes of practice. For costing purposes it is assumed procedural work would add \$200 to MBS for 5 per cent of services (excluding practice nurses and psychologists).

If nurses and wider incentives were covered by the program the number of referred allied health services would increase by a factor of five with all other assumptions fixed; additional cost of \$330m per annum would apply.

These costs are only MBS & PBS and do not include out of pocket patient costs nor any offsets to currently publicly provided services.

\$22.5 million has been allocated for 2010–11 in the Australian Government Budget 2009–10 to fund the expansion of MBS and PBS to nurse practitioners outside acute care and midwives in collaborative models of care.²⁹⁴

293 Extrapolated from Medicare Australia Annual Report 2007-08

294 DoHA 2009–10 Budget

RECOMMENDATION 100

We recommend a new education framework for all education and training of health professionals: moving towards a flexible, multi-disciplinary approach to the education and training of all health professionals; incorporating an agreed multi-disciplinary approach to the education and training of all health professionals; incorporating an agreed competency-based framework as part of a broad teaching and learning curricula for all health professionals; establishing a dedicated funding stream for clinical placements for undergraduate and postgraduate students; and ensuring clinical training infrastructure across all settings (public and private, hospitals, primary health care and other community settings).

Additional cost

The net additional cost of this may be nil, as COAG²⁹⁵ has committed additional funding for undergraduate and postgraduate clinical training and clinical training infrastructure as part of the health workforce reform package. Accordingly the Commission proposal does not entail additional expenditure above what would be required by the existing commitment.

Costing Assumptions

Commonwealth funding for clinical training subsidies²⁹⁶

	2009-10	2010-11	2011-12	2012-13
	\$m	\$m	\$m	\$m
Clinical training subsidy – undergraduates	67.48	140.25	143.66	145.08
Clinical training subsidy – postgraduates			32.81	53.42
Clinical training – supervision capacity	4	6	8	10
Clinical training simulated learning environments	0.25	7.48	20	20.75
Total	71.73	153.73	204.47	229.25

RECOMMENDATION 101

To ensure better collaboration, communication and planning between the health services and health education and training sectors we recommend the establishment of a National Clinical Education and Training Agency: to advise on the education and training requirements for each region; to assist with planning clinical education infrastructure across all service settings including rural and remote areas; to form partnerships with local universities, vocational education and training organisations, and professional colleges, to acquire clinical education placements from health service providers, including a framework for activity-based payments for undergraduates' clinical education and postgraduate training; to promote innovation in education and training of the health workforce; as a facilitator for the provision of modular competency-based programs to up-skill health professionals (medical, nursing, allied health and aboriginal health workers) in regional, rural and remote Australia; and to report every three years on the appropriateness of accreditation standards in each profession in terms of innovation around meeting the emerging health care needs of the community. Further we recommend that the governance, management and operations of the Agency should include a balance of clinical and educational expertise, public and private health services representation in combination with Commonwealth and state health agencies. While the Agency has an overarching leadership function it should support implementation and innovation at the local level.

295 http://coag.gov.au/coag_meeting_outcomes/2008-11-29/attachments.cfm#attachmenta

296 National Partnership Agreement on Hospital and Health Workforce Reform

Additional cost

The net additional cost of this recommendation may be nil, as COAG²⁹⁷ has committed additional funding for undergraduate and postgraduate clinical training and clinical training infrastructure as part of the health workforce reform package. Accordingly the Commission proposal does not entail additional expenditure above what would be required by the existing commitment.

Costing Assumptions

Commonwealth funding for National Health Workforce Agency²⁹⁸

	2009-10	2010-11	2011-12	2012-13
	\$m	\$m	\$m	\$m
National Health Workforce Agency	25	30	35	35
Workforce redesign	20	30	15	6

RECOMMENDATION 102

We support national registration to benefit the delivery of health care across Australia.

Additional cost

The net additional cost of this is proposed to be zero, as government has already made a prior commitment to national registration of health professionals. Accordingly the Commission's proposal does not entail additional expenditure above what would be required by the existing commitment.

RECOMMENDATION 104

We recommend that a higher proportion of new health professional educational undergraduate and postgraduate places across all disciplines be allocated to remote and rural regional centres, where possible in a multidisciplinary facility built on models such as clinical schools or university departments of Rural Health.

Additional cost

The net additional cost of this is proposed to be zero, as government has already made a prior commitment of \$40 million in capital infrastructure funding to establish or expand education and training at major regional hospitals as part of the Rural Clinical Program.²⁹⁹

297 http://coag.gov.au/coag_meeting_outcomes/2008-11-29/attachments.cfm#attachmenta

298 National Partnership Agreement on Hospital and Health Workforce Reform

299 National Partnership Agreement on Hospital and Health Workforce Reform

RECOMMENDATION 105

To promote research and uptake of research findings in clinical practice, we recommend that clinical and health services research be given higher priority. In particular we recommend that the Commonwealth increase the availability of part-time clinical research fellowships across all health sectors to ensure protected time for research to contribute to this endeavour.

Additional cost \$100 million

Costing Assumptions The NHMRC’s planned funding commitments for health and medical research in Australia over the Budget and forward estimates is expected to rise to over \$880 million in 2010 and then stabilise at around \$780 million over the next three years, with 63 per cent of funding supporting research projects, 25 per cent supporting capacity building fellowships and scholarships, and 12 per cent supporting the translation of health and medical research into evidence-based practice.³⁰⁰

NHMRC funding has been around 1.3 per cent of all Health and Ageing portfolio in recent years. Using departmental estimates for spending to 2011–12 and then projecting portfolio and NHMRC spending forward based on those growth rates, NHMRC funding should reach \$890 million by 2014–15.³⁰¹ A further \$100 million per year is needed to reach this level of funding.

RECOMMENDATION 109

To enhance the spread of innovation across public and private health services, we recommend that: the National Institute of Clinical Studies broaden its remit to include a ‘clearinghouse’ function to collate and disseminate innovation in the delivery of safe and high quality health care; health services and health professionals share best practice lessons by participating in forums such as breakthrough collaboratives, clinical forums, health roundtables, and the like; and a national health care quality innovation awards program is established.

Additional cost \$8 million

Costing Assumptions The proposed national function estimated funding requirement is based on the current level of Australian government funding of existing national health bodies

300 DOHA 2009–10 Budget National Health and Medical Research Council, At: [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2009-2010_Health_PBS_sup1/\\$File/Department%20of%20Health%20and%20Ageing%20PBS.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2009-2010_Health_PBS_sup1/$File/Department%20of%20Health%20and%20Ageing%20PBS.pdf)

301 Research Australia (2009), Trends in Health and Medical research Funding

RECOMMENDATION 111

The Australian Commission for Safety and Quality in Health Care should be established as a permanent, independent national body. With a mission to measurably improve the safety and quality of health care the ACS&QHC would be an authoritative knowledge-based organisation responsible for: Promoting a culture of safety and quality across the system: disseminating and promoting innovation, evidence and quality improvement tools; recommending national data sets with a focus on the measurement of safety and quality; identifying and recommending priorities for research and action; advocating for safety and quality; providing advice to governments, bodies (e.g. NHMRC, TGA), clinicians and managers on 'best practice' to drive quality improvement. Analyse and report on safety and quality across all health settings: reporting and public commentary on policies, progress and trends in relation safety and quality; develop and conduct national patient experience surveys; report on patient reported outcome measures. Monitor and assist in regulation for safety and quality: recommending nationally agreed standards for safety and quality, including collection and analysis of data on compliance against these standards. The extent of such regulatory responsibilities requires further consideration of other compliance activities such as accreditation and registration processes.

Additional cost \$34 million

Costing Assumptions The estimated funding requirement for the proposed national function is based on the current level of Australian government funding of current national health bodies.

The Australian Commission on Safety and Quality in Health Care is currently funded at \$11 million however this needs to be ongoing and needs to reflect an expanded role including accreditation, registration, promotion and reporting.

RECOMMENDATION 123

With respect to the broader e-health agenda in Australia, we concur with, and endorse the directions of the National E-Health Strategy Summary (December 2008), and would add that: There is a critical need to strengthen the leadership, governance and level of resources committed by governments to giving effect to the planned National E-Health Action Plan. This Action Plan must include provision of support to public health organisations and incentives to private providers to augment uptake and successful implementation of compliant e-health systems. It should not require government involvement with designing, buying or operating IT systems. In accordance with the outcome of the 2020 Summit and our direction to encourage greater patient involvement in their own health care, that governments collaborate to resource a national health knowledge web portal (comprising e-tools for self-help) for the public as well as for providers. The National Health Call Centre Network (healthdirect) may provide the logical platform for delivery of this initiative. Electronic prescribing and medication management capability should be prioritised and coordinated nationally, perhaps by development of existing applications (such as PBS online), to reduce medication incidents and facilitate consumer amenity.

Additional cost \$1,185–\$1,865 million

Costing Assumptions \$600–\$900 million implementation and adoption of national standards including:

- investment in bringing existing public and private systems to a level that will allow them to operate with a broader electronic health care system, including interfaces;
- encouragement of the development and implementation of new e-health solutions that apply these standards and implement the interfaces necessary to allow broad integration. This would include solutions

to allow consumers access to and use of their own personal health information.

- Implementation of additional enablers of national information exchange, such as national indexing, strong privacy management and authentication services.
- Investment in the industry infrastructure required to test and accredit the adoption of eHealth.

\$500–\$800 million e-health teaching, training, change management and support to health care practitioners targeting:

- encouragement of the active use of high priority e-Health solutions prior to the mandated use of these solutions to provide data that can be integrated into a person-controlled electronic health record (such investment does not replace investments by the private and public sector in the development of their internal e-health solutions, but helps ensure that they can contribute to the national system);
- health information training for clinicians, including in universities, continuing education and in specialist health contexts (such as hospital emergency departments);
- workplace change, enabling new workplace practices that can only be adopted with e-health solutions in-place;
- delivery of new tools and capabilities that leverage e-health information to deliver provider efficiencies (e.g. new electronic clinical registries) and enhanced health monitoring (such as bio-surveillance capabilities).

\$35–\$65 million consumer marketing program

\$50–\$100 million research, performance monitoring and governance

These costs are in addition to developments to date funded by COAG commitments of \$318m and industry and individual practitioner investment and do not include hospital information system infrastructure.³⁰²

GLOSSARY AND ACRONYMS



Aboriginal Community Controlled Health Services – Primary health care services initiated and managed by local Aboriginal communities to deliver holistic, comprehensive, and culturally appropriate care to the community which controls it (through a locally elected Board of Management).

ABS – Australian Bureau of Statistics.

ACAT – Aged Care Assessment Team.

Access block – A term applied to the situation when a person who has presented to a hospital emergency department and has been judged by the attending doctor to require admission for further care is unable to be admitted for that care for more than eight hours.

ACSQHC – Australian Commission on Safety and Quality in Health Care.

Activity-based funding (ABF) – A patient activity funding approach which is based on the volume and type of patients treated (casemix).

Acute hospitals – Public and private hospitals which provide treatment or care to patients for a condition requiring immediate care or intervention. The average length of stay is relatively short.

Admitted patient – A patient for whom the hospital or health care facility has accepted responsibility for providing same-day or overnight care or treatment.

Advance care planning – A process whereby a patient, in consultation with health care providers, family members and important others, makes decisions about his or her future health care, should he/she become incapable of participating in medical treatment decisions. An advance care plan allows people to identify on a step-by-step basis how they want their symptoms managed and their treatment preferences.

AIHW – Australian Institute of Health and Welfare.

Allocative efficiency – The best allocation of resources in the health system such that the allocated inputs yield the best possible outcomes. An 'allocatively efficient' health system produces an 'optimal mix' of health interventions.

Ambulatory care – Care on a non-admitted or outpatient basis; patients usually 'walk in and walk out'.

Area of Workforce Shortage (AOWS) – An Area of Workforce Shortage is one in which the community is considered to have less access to medical services than that experienced by the population in general, assessed as those areas that fall below the national average of Full-time Workload Equivalent general practitioners (FWE GPs). Inner metropolitan areas cannot be deemed an AOWS.

Australian Refined Diagnosis Related Groups (AR-DRGs) – A patient classification system (DRGs), refined for use in Australia that provides a clinically meaningful way of relating types of patients treated in a hospital to the resources required to treat them. AR-DRGs use information in the patient's hospital record such as diagnoses, procedures, co-morbidities, complications, and age to classify the patient.

Average length of stay (ALOS) – The average duration of stay for admitted patient episodes.

Bulk-billing – The process by which a medical practitioner or optometrist sends the bill for services direct to Medicare, so there is no cost to the patient. Also known as direct billing.

Casemix – A description of the numbers and types of patients seen in a health care facility usually based on a patient classification system such as AR-DRGs. It gives the health care industry a consistent method of describing types of patients, their treatment and associated costs.

Casemix Rehabilitation and Funding Tree (CRAFT) – A ‘casemix’ classification for sub-acute care and rehabilitation, in Victoria.

Chronic diseases – Term applied to a diverse group of diseases, such as heart disease, cancer and arthritis that tend to be long-lasting and persistent in their symptoms or development. Although these features also apply to some communicable diseases (infections), the term is usually confined to non-communicable diseases.

COAG – Council of Australian Governments.

Community Aged Care Package (CACP) – This program provides a planned and managed package of community care for people with complex care needs who would like to remain living in their own home. For example, a package may help with personal care, domestic assistance or possibly help participation in social activities.

Compulsory treatment order (of involuntary mental health patients) – Is a legal order issued upon a person who is mentally ill and has either refused treatment or is considered unfit to consent to treatment. It authorises their detention in a hospital or care facility.

Cultural safety – Wide variety of definitions. The National Aboriginal Community Controlled Health Organisation (NACCHO) uses: An environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening.

Dental health – For the purposes of this report, dental health includes oral health.

Dentate – Having one or more natural teeth.

Disability – A loss or restriction of functional ability or activity as a result of impairment of the body or mind.

Disability-adjusted life year (DALY) – Years of healthy life lost through premature death or living with disability due to illness or injury.

Efficient price of care – Where price equals the minimum cost of caring for a certain category of patient. That is, where the optimal set of inputs is chosen that minimises the cost of producing the best possible outcome for the patient.

E-health – Is the combined use of electronic communication and information technology in the health sector.

Elective procedure – A procedure which is clinically necessary but which can be delayed for at least 24 hours. Sometimes referred to as a ‘booked’ or ‘planned’ procedure.

End of life care – End of life care is care provided to people who are living with, and impaired by, an eventually fatal condition. It is not limited by prognosis. End of life care can be provided by all health care professionals and is not limited to care provided by palliative care services or specialists.

Episode of care – A period of health care of a certain type with a defined start and end.

EPPIC – Early Psychosis Prevention and Intervention Centre.

Extended Aged Care at Home (EACH) – Individually planned and coordinated packages of care, tailored to help frail older Australians to remain living at home. They are funded by the Australian Government to provide for the complex care needs of older people.

Extended Aged Care at Home Dementia (EACHD) – As for EACH but with a higher level of funding to provide additional care at home for people with dementia.

Extra service – Extra service status allows aged care homes to offer a 'significantly higher' than average standard of accommodation, services and food in return for additional payment under certain conditions.

First Ministers – A collective term referring to all heads of government.

Genomics – The study of the genomes of individuals or organisms, usually to determine the DNA sequence or genetic map.

GP – General (medical) practitioner.

Goods and Services Tax (GST) – The GST is a broad-based tax of 10 per cent on most goods, services and other items sold or consumed in Australia.

Gross Domestic Product (GDP) – A statistic commonly used to indicate national wealth. It is the total market value of goods and services produced within a given period after deducting the cost of goods and services used up in the process of production but before deducting allowances for the consumption of fixed capital.

Home and Community Care (HACC) – A program which provides services such as domestic assistance, personal care as well as professional allied health care and nursing services, in order to support older Australians, younger people with a disability and their carers to be more independent at home and in the community and to reduce the potential or inappropriate need for admission to residential care. HACC is a joint Australian, state and territory government initiative.

Health – A term relating to the state of a person's physical, mental, and psychosocial wellbeing.

Health literacy – The knowledge and skills required to understand and use information relating to disease prevention and treatment, safety and accident prevention, first aid, emergencies, avoiding health risks and staying healthy. It also refers to an individual's understanding of the services available within the health system and how to access and navigate processes to seek appropriate care.

Health outcome – A change in the health of an individual or population due wholly or partly to a preventive or clinical intervention.

Health promotion – Activities to improve health and prevent disease, often described as the process that helps individuals and communities to increase control over the determinants of health.

Health status – An individual's or population's overall level of health, taking into account various aspects such as life expectancy, mortality, amount of disability, levels of disease risk factors and so on.

High care – Residential high care includes: accommodation-related services and personal care services (as for low care); plus nursing services and equipment – for example, equipment to assist with mobility, incontinence aids, basic pharmaceuticals, provision of nursing services and procedures, administration of medications, provision of therapy services and provision of oxygen.

Indicator – A key statistical measure selected to help describe (indicate) a situation concisely, track progress and performance, and act as a guide to decision making. It may have an indirect meaning as well as a direct one; for example, Australia's overall death rate is a direct measure of mortality but is often used as a major indicator of population health.

Inpatient – Someone admitted into hospital (or another health service) for care.

International medical graduate (IMG) – Refer to *Overseas-trained doctor*.

Length of stay (LOS) – Duration of hospital stay, calculated by subtracting the date the patient is admitted from the day of separation. All leave days, including the day the patient went on leave, are excluded. A same-day patient is allocated a length of stay of one day.

Life expectancy – An indicator of how long a person can expect to live on average given prevailing mortality rates. Technically, it is the average number of years of life remaining to a person at a specified age, assuming current age-specific mortality rates continue during the person's lifetime.

Low care – Residential low care includes accommodation-related services such as general laundry, cleaning services and the provision of staff continuously on call to provide emergency assistance; and personal care services such as assistance with the activities of daily living and communication; rehabilitation support; assistance in obtaining health and therapy services; and support for people with cognitive impairments.

MBS – Medicare Benefits Schedule.

Medicare – Australia's universal health care system which provides access to free treatment as a public (Medicare) patient in a public hospital and free or subsidised treatment by medical practitioners including general practitioners, specialists, participating optometrists or dentists (for specified services only). Medicare is financed through progressive income tax and an income-related Medicare levy.

Mental illness or disorder – A clinically significant behavioural or psychological pattern that occurs in an individual and is usually associated with distress, disability or increased suffering. The term 'serious mental illness' is used to refer to a more severe or long lasting disorder.

Morbidity – Refers to ill health in an individual and to levels of ill health in a population or group.

Multidisciplinary care – Where health professionals from multiple disciplines work together to provide team-based care to a patient.

NATSIHA – National Aboriginal and Torres Strait Islander Authority – a body proposed by the NHHRC.

NHHRC – National Health and Hospitals Reform Commission.

NHMRC – National Health and Medical Research Council.

NICS – National Institute of Clinical Studies.

Not-for-profit – An organisation that does not distribute profits or surpluses to personal owners or shareholders.

Nurse practitioner – A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice.

Operational (technical) efficiency – Where it is impossible to produce, with given technology, a larger output from the same inputs, or the same output with less inputs. Operational efficiency is determined by the difference between the observed ratio of combined quantities of an entity's output to input and the ratio achieved by best practice.

Out-of-pocket costs – The total costs incurred by individuals for health-care services over and above any refunds from Medicare and private health insurance funds.

Outpatient – A person treated or seen in a hospital clinic without being admitted.

Overseas-trained doctor (OTD) – A doctor whose basic medical qualifications and/or specialist qualifications were acquired in a country other than Australia.

Palliative care – Palliative care is specialist care provided for all people living with, and dying from, an eventually fatal condition and for whom the primary goal is quality of life.

Patient days – The number of full or partial days of stay for patients who were admitted for an episode of care and who underwent separation during the reporting period. A patient who is admitted and separated on the same day is allocated one patient day.

PBS – Pharmaceutical Benefits Scheme.

Performance indicators – Measures of the efficiency and effectiveness of health services in providing health care.

Perinatal – Pertaining to or occurring in the period shortly before or after birth (usually up to 28 days after).

Personalised medicine or health care – Uses knowledge of genetics to predict disease development and influence decisions about lifestyle choices or to tailor medical practice to an individual.

Potential years of life lost (PYLL) – Number of potential years of life lost in a population as a result of premature death.

Practice nurse – A practice nurse is a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice. Practice nurses deliver primary health care in a general practice setting.

Prevention (of disease or ill health) – Action to reduce or eliminate the onset, causes, complications or recurrence of disease or ill health.

Primary health care – 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.

Primary Care Trust – A UK health service commissioning agency based in primary care. They purchase care for their patients from local hospitals.

Private hospital – A hospital which generates most of its revenue by charging patients for services.

Private admitted patient – Person admitted to a private hospital, or person admitted to a public hospital who elects to choose the doctor(s) who will treat them or to have private ward accommodation. This means they will be charged for medical services and accommodation.

Proteomics – The study of the full set of proteins encoded by a genome.

Public health – A term which variously refers to the level of health in the population, to actions that improve that level or to related study. Activities aimed at benefiting a population tend to emphasise prevention, protection and health promotion as distinct from treatment tailored to individuals with symptoms. Examples include provision of a clean water supply and good sewerage, conduct of anti-smoking education campaigns, and screening for diseases such as cancer of the breast and cervix.

Public hospital – A hospital which is predominantly funded by governments to treat people free of charge.

Public patient – A patient admitted to a public hospital who has agreed to be treated by doctors of the hospital's choice and to accept shared ward accommodation. This means that the patient is not charged any fees.

Relocation Incentive Grants for Outer Metropolitan Practice – The Relocation Incentive Grant was introduced in 2003–04 to encourage doctors to work in outer-metropolitan practices. Grants are payable to doctors who relate to an existing outer-metropolitan practice or to set up a new practice in an outer metropolitan location.

Rural, Remote and Metropolitan Areas (RRMA) – The Rural, Remote and Metropolitan Areas (RRMA) classification was developed in 1994 by the Department of Primary Industries and Energy and the then Department of Human Services and Health, and breaks down geographical areas into metropolitan, rural and remote areas. It should be noted that this measure has not been updated and continues to be based on the SLA boundaries and population of the ABS 1991 Census.

Rural Clinical Schools – Rural Clinical Schools provide teaching and clinical practice sites for students of medicine. They are considered a part of a university's medical school and are located in a rural area.

Risk factor – Any factor which represents a greater risk of experiencing a health disorder or other unwanted condition or event. Some risk factors are regarded as causes of disease, others are not necessarily so. Along with their opposites, protective factors, risk factors are known as *determinants*.

Social inclusion – A socially inclusive society is defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity.

Specialist – Usually refers to a medical graduate who has undertaken a further course of study recognised by an accredited College. It may also refer to a midwife, allied health professional, pharmacist, dental/oral health professional who is an expert in a particular field of health care.

Specialist Obstetrician Locum Scheme (SOLS) – The program provides locum relief to rural obstetricians through subsidised locum support for 14 days and an optional additional two weeks of unsubsidised support. This allows rural obstetricians to take personal leave or undertake professional development.

Specific Purpose Payment (SPP) – Grants made by the Commonwealth to states under section 96 of the Constitution which enables the parliament to grant financial assistance to any state on such terms and conditions as the parliament thinks fit.

Statistical Local Area (SLA) – The smallest spatial unit or level of geography contained in the Australian Standard Geographical Classification (ASGC). SLAs cover Australia without gaps or overlaps. The Australian Standard Geographical Classification (ASGC) is a hierarchical classification system of geographical areas and consists of a number of interrelated structures. It provides a common framework of statistical geography and enables the production of statistics which are comparable. There are 1426 SLAs covering Australia under the ASGC used for the ABS 2006 Census.

Strategic Health Authority – A UK health service planning organisation.

Sub-acute, Non-acute and Palliative care (SNAP) classification – A 'casemix' classification for sub-acute care, rehabilitation, non-acute care and palliative care used in New South Wales.

Sub-acute services – Includes rehabilitation and geriatric evaluation and management care. Some sub-acute care is colloquially referred to as 'low dependency' or 'step up' and 'step down' care, meaning that it can either precede (and potentially avoid) a hospital admission or follow an acute hospital admission. Sub-acute services also include care provided under the new Transition Care program. Most sub-acute services can be provided on either an inpatient or ambulatory basis.

Transition Care – Transition Care aims to help people leaving hospital to improve their independence and confidence. It provides a package of services including low intensity therapy and personal and/or nursing care to assist with continued recovery after hospitalisation.

Triage – Initial assessment in an emergency department, usually by a nurse, as to the urgency with which a person needs to be seen.

Triage category or triage scale – People presenting at a hospital emergency department are assigned to one of five triage categories according to their urgency:

- resuscitation
- emergency
- urgent
- semi-urgent
- non-urgent

University Departments of Rural Health (UDRH) – University Departments of Rural Health are located in rural areas and provide clinical placements and training for medical, nursing and allied health students. They also offer education, support and research opportunities for health service providers in the local area. They are often collaborative enterprises involving more than one university.

Vertical fiscal imbalance – When the revenues of different levels of government (in this case state/territory and Australian governments) do not match their expenditure responsibilities.

Victorian Ambulatory Classification System (VACS) – A ‘casemix’ classification for outpatient services.

Vocational Education and Training (VET) – A national system designed to skill workers to work in particular industries. Health occupations trained within the VET sector include enrolled nurses, allied health assistants and personal care workers. VET covers the following levels: Certificate, Diplomas and Advanced Diplomas within the Australian Qualifications Framework.