

Reform Directions

1. Building good health and wellbeing into our communities and our lives

- 1.1 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.
- 1.2 We propose 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.
- 1.3 We propose the preparation of a regular report that tracks our progress as a nation in tackling health inequity.
- 1.4 We support 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.
- 1.5 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.
- 1.6 We propose 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 governments on progress towards achieving better health outcomes under the ten-year goals.
- 1.7 We propose the establishment of an independent national health promotion and prevention agency. This agency would be responsible for national leadership on the ten-year health 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.
- 1.8 We propose that the national health promotion and prevention agency would also collate and disseminate information about the efficacy and cost effectiveness of health promotion and prevention interventions.

- 1.9 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, employers and governments.
- 1.10 We propose 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 school.
- 1.11 We encourage all relevant groups (including health services, health professionals, non-government organisations, media, private health insurers 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.

2. Creating strong primary health care services for everyone

- 2.1 We propose that, to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding.
- 2.2 We propose that, in its expanded role, the Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres.
- 2.3 We want young families and people with chronic and complex conditions (including people with a disability or a long-term mental illness) to have the option of enrolling with a single primary health care service to improve care. To support this, we propose that:
- There will be grant funding to support multidisciplinary clinical 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.
 - Over the longer term, payments will be developed that bundle the total cost of care of enrolled individuals over a course of care or period of time, in preference to existing fee-based payments.
- 2.4 We support 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 and quality care.
- 2.5 We support improving the way in which primary health care professionals and specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting. These arrangements should promote the vital role of primary health care professionals in the ongoing management and support of people with chronic and complex conditions.
- 2.6 We believe that service coordination and population health planning priorities could be enhanced at the local level through the establishment of Divisions of Primary Health Care, evolving from or replacing the existing Divisions of General Practice. These divisions will need to be of an appropriate size to provide efficient and effective coordination.

- 2.7 We propose facilitating access to care where doctors are scarce. Commencing in remote and some rural areas:
- Medicare rebates should apply to relevant diagnostic services and specialist medical services ordered or referred by nurse practitioners and other registered health professionals according to defined scopes of practice determined by health professional registration 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, credentialed for defined scopes of practice.
- 2.8 In accordance with our later proposal for the establishment of a National Aboriginal and Torres Strait Islander Health Authority, we would expect that this Authority should be responsible for the purchasing of services that encourage and promote best practice and quality outcomes in primary health care for Aboriginal and Torres Strait Islander peoples wherever they elect to seek their health care.
- 2.9 We support the development of a person-controlled electronic personal health record. We will explore the prerequisites and incentives to allow us to reach this goal in our final report.

3. Nurturing a healthy start to life

- 3.1 We propose 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, 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.
- 3.2 We propose 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.
- 3.3 We propose 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.
- 3.4 In the antenatal period, in addition to good universal primary health care, we propose targeted care for women with special needs or at risk, such as home visits for very young, first-time mothers.

- 3.5 We propose 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.
- 3.6 We propose that, as part of its set of core services, 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.
- 3.7 We propose that, 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.
- 3.8 We propose that all primary schools have access to a school nurse for promoting and monitoring children's health, development and wellbeing, particularly through the important transition to primary school.
- 3.9 We propose that responsibility for nurturing a healthy start to life be embedded in primary health care to ensure continuity of care and a comprehensive understanding of a child's health needs. 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 a child and their family.

4. Ensuring timely access and safe care in hospitals

- 4.1 We propose development and adoption of National Access Guarantees for planned procedures and National Access Targets for emergency care. For example:
- a national access target for people requiring an acute mental health intervention (measured in hours);
 - a national access guarantee for patients requiring coronary artery surgery or cancer treatment (measured in weeks/days); and
 - a national access guarantee for patients requiring other planned surgery or procedures (measured in months).
- These National Access Guarantees should be developed incorporating clinical, economic and community perspectives through vehicles like citizen juries.
- Under the National Access Targets for emergency access, all hospital emergency departments should meet the triage access targets specified in *Beyond the Blame Game*, as well as additional measures of performance in promptly admitting people from emergency departments where they need it. These National Access Targets operate at the level of individual hospitals.
- 4.2 A share of the funding potentially available to public hospitals should be linked to meeting (or improving performance towards) the access guarantees and targets, payable as a bonus.

- 4.3 We propose there be financial incentives to reward good performance in outcomes and timeliness of care. One element of this should be for timely provision of discharge information including details of any follow-up care required.
- 4.4 We support 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.
 - The costs to hospitals with a major emergency load of having to maintain capacity to admit people promptly should be recognised in the funding arrangements.
- 4.5 We propose that all hospitals review provision of ambulatory services (outpatients) to ensure they are designed around patients' needs and, where possible, located in community settings.
- 4.6 To improve quality, 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.
- 4.7 To improve accountability, we propose 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.
- 4.8 We propose that public and private hospital episode data is collected nationally using a patient's Medicare card number to understand better people's use of health services and outcomes across different care settings.
- 4.9 We suggest 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.
- 4.10 We propose a nationally led, systemic approach to encouraging, supporting and harnessing clinical leadership within hospitals and broader health settings and across professional disciplines.

5. Restoring people to better health and independent living

- 5.1 We want to increase the visibility of, and access to, sub-acute services through more directly linking funding 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.
- 5.2 We support a dual approach to funding of sub-acute services, comprising a mix of activity-based funding with the use of incentive payments related to improving outcomes for patients.
- 5.3 We propose 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.

- 5.4 We propose that investment in sub-acute services infrastructure be one of the top priorities for the Health and Hospitals Infrastructure Fund.
- 5.5 We need 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.
- 5.6 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. Ensuring affordable access to such equipment will be considered under reform direction 13.4 that foreshadows further work on the development of integrated safety nets.

6. Increasing choice in aged care

- 6.1 We believe that funding should be more directly linked to people rather than places, and to those who are most likely to need care. We propose changing the limit on provision of aged care subsidies from **places** per 1000 people aged **70 or over** to **care recipients** per 1000 people aged **85 or over**.
- 6.2 We suggest 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 regulated limits on the number of places has resulted in sufficient increased competition in supply and price.
- 6.3 We propose 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.
- 6.4 We support consolidating aged care under the Commonwealth by making aged care under the Home and Community Care (HACC) program a direct Commonwealth program.
- 6.5 We propose developing and introducing streamlined, consistent assessment for eligibility for care across all aged care programs.
- 6.6 We propose 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.
- 6.7 We propose 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).
- 6.8 We propose 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.
- 6.9 We propose that once assessments, 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.

- 6.10 We propose that all aged care providers (community and residential) should be required to have staff trained in supporting care recipients to complete advanced care plans for those care recipients who wish to do so.
- 6.11 We propose that funding be provided for use by residential aged care providers to strike arrangements with primary care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes.
- 6.12 We propose:
- increased use of electronic clinical records in aged care homes, including capacity for electronic prescribing by attending medical 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 (see Chapter 4) include timely provision of good information on a person's hospital care to the clinical staff of their aged care provider, subject to patient consent.

7. Caring for people at the end of life

- 7.1 We propose building the capacity and competence of primary health care services, including the Comprehensive Primary Health Care Centres proposed in Chapter 2, 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.
- 7.2 We support 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.
- 7.3 We propose that additional investment in specialist palliative care services be directed to support more availability of these services to people at home in the community.
- 7.4 We propose that funding be provided for the national implementation of the Respecting Patient Choices program (advance care planning) across all residential aged care services.
- 7.5 We support greater awareness and education among health professionals of the common law right of people to make decisions on their medical treatment, including the 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.

8. Closing the health gap for Aboriginal and Torres Strait Islander peoples

- 8.1 We propose 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.

- 8.2 We propose an investment strategy for Aboriginal and Torres Strait Islander Australians' 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.
- 8.3 We propose establishing a function to build and expand organisational capacity for Community Controlled Health Services to provide and broker comprehensive primary health care services. We would welcome feedback on the appropriate auspicing body or agency for such a support function.
- 8.4 We propose strengthening the purchasing role to lead the additional investment in Aboriginal and Torres Strait Islander health. This could be achieved by the establishment of a National Aboriginal and Torres Strait Islander Health Authority to purchase services specifically for Aboriginal and Torres Strait Islander Australians and their families as a mechanism for closing the gap. This Authority would purchase health services from accredited providers with a focus on outcomes to ensure high quality and timely access.
- 8.5 We propose that accreditation processes for health services and education providers incorporate, as core, specific Indigenous modules to ensure quality clinical and culturally appropriate services.
- 8.6 We propose 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.

9. Delivering better health outcomes for remote and rural communities

- 9.1 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 propose:
- 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.
- 9.2 We propose that care for people in remote and rural locations necessarily involves bringing care to the person or the person to the care, through:
- 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.

We propose that funding mechanisms be developed to support all these elements.

- 9.3 We propose 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.
- 9.4 We propose 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.

10. Supporting people living with mental illness

- 10.1 We propose 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.
- 10.2 We propose that the Early Psychosis Prevention and Intervention Centre model be implemented nationally so that early intervention in psychosis becomes the norm.
- 10.3 We believe that every acute mental health service should have a rapid-response outreach team for those individuals experiencing psychosis.
- 10.4. We propose 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.
- 10.5 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 accreditation processes.
- 10.6. We propose that each state and territory government provide those suffering from severe mental illness with stable housing that is linked to support services.
- 10.7 We want governments to increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support.
- 10.8 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.
- 10.9 We propose that state and territory governments recognise the compulsory treatment orders of other Australian jurisdictions.
- 10.10 We propose 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 reside; and
 - someone appropriate at that location is informed.
- 10.11 We propose a sustained national community awareness campaign to increase mental health literacy and reduce the stigma attached to mental illness.

- 10.12 We propose there must be more effective mechanisms for consumer and carer participation and feedback to shape programs and service delivery.

11. Improving oral health and access to dental care

- 11.1 We propose that Australia should have a scheme 'Denticare Australia' for universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay.
- 11.2 We propose that 'Denticare Australia' be based on a mixed approach of public and private cover. The additional costs would be funded by an increase in the Medicare Levy of 0.75 per cent of taxable income, with people opting either to become a member of a dental health plan (with a private insurer), or to use public dental services.
- 11.3 We support an equitable approach to financing a universal dental scheme. Under the proposed approach, the funding of dental services will be linked to ability to pay through an increase in the Medicare Levy. We estimate that under this approach:
- Many people will pay no more than they currently pay for dental care; the increase in Medicare Levy of 0.75 per cent of taxable income will be smaller than existing out-of-pocket costs for dental services for many people.
 - People on low incomes will pay considerably less and have much better access to dental health services.
- 11.4 We support 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.
- 11.5 We propose the national expansion of the pre-school and school dental programs.
- 11.6 We propose that additional funding be made available for improved oral health promotion, with interventions to be decided based upon relative cost-effectiveness assessment.

12. Strengthening the governance of health and health care

- 12.1 We propose a range of functions that should be led and governed at the national level, including leadership for patient safety and quality (including service accreditation), health promotion and prevention, professional registration, workforce planning and education, performance reporting, private hospital regulation, and technology assessment.
- 12.2 We propose that the Commonwealth should take responsibility for policy and funding of all primary health care.
- 12.3 We propose to give further consideration to the following three options for reform of governance:
- (A) Shared responsibility with clearer accountability.* Retain both Commonwealth and state and territory involvement but re-align responsibilities between them, with the Commonwealth:
- becoming responsible for all primary health care funding and policy;

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

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

(B) Commonwealth to be solely responsible for all aspects of health care, delivering through regional health authorities. Transfer all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing and funding:

- regional health authorities to take responsibility for former state health services such as public hospitals and community health services, in parallel to continued national programs of medical and pharmaceutical benefits and aged care subsidies.

(C) Commonwealth to be solely responsible for all aspects of health and health care, establishing compulsory social insurance to fund local delivery. Transfer all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing:

- a tax-funded community insurance scheme under which there would be multiple, competing health plans for people to choose from, which would be required to cover a mandatory set of services including hospital, medical, pharmaceutical, allied health and aged care.

13. Raising and spending money for health services

13.1 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
- evidence-based investment in strengthened primary health care services and health promotion and prevention to keep people healthy will help to contain future growth in spending.

13.2 We want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade.

13.3 We propose a systematic mechanism to formulating health care priorities that incorporates clinical, economic and community perspectives through vehicles like citizen juries.

13.4 We will explore new safety net arrangements that are more integrated, cover a broader range of health costs and are family-centred to protect families and individuals from unaffordable high out-of-pocket costs of health care.

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

13.6 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-serviced locations and populations.

13.7 We believe that additional capital investment will be required on a transitional basis to facilitate our reform directions. In particular, we propose that:

- priority areas for new capital investment should include: 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 especially in new and underdeveloped 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, as outlined above.

14. Working for us: a sustainable health workforce for the future

14.1 We propose supporting our health workforce by:

- improving workplace culture, management and leadership skills at all levels of the system. We would welcome feedback on proven mechanisms to achieve this; and
- implementing models that formally involve all health professionals in guiding the future directions of health reform and place value on their ongoing commitment to delivering care (e.g. Clinical Senates and Taskforces).

14.2 We propose facilitating access to care where doctors are scarce. Commencing in remote and some rural areas:

- Medicare rebates should apply to some diagnostic services and specialist medical services ordered or referred by nurse practitioners and other registered health professionals according to defined scopes of practice determined by health professional registration 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, credentialed for defined scopes of practice.

- 14.3 We endorse a new education framework for all education and training of health professionals including:
- adopting a competency-based framework;
 - moving towards a flexible, multi-disciplinary approach to the education and training of 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).
- 14.4 We propose the establishment of a National Clinical Education and Training Agency:
- to advise on the adequacy of projected provision of health professional education in the university and vocational education sectors within each major region;
 - to purchase in partnership with universities, vocational education and training, and colleges, clinical education placements from health service providers, including payments for undergraduates' clinical education and postgraduate training;
 - to promote innovation in education and training of the health workforce;
 - as an aggregator and 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 to perform tasks and address health needs met by other health professionals in major metropolitan areas; 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.
- 14.5 We support national registration to benefit the delivery of health care across Australia.
- 14.6 We propose 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.
- 14.7 We propose 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.

15. Fostering continuous learning in our health care system

- 15.1 The Commonwealth Government should increase the priority of health services research to facilitate the uptake of research findings into practice. Increasing the availability of part-time clinical research fellowships across all health sectors to ensure protected time for research may contribute to this endeavour.
- 15.2 We further propose that infrastructure funding (indirect costs) follow direct grants whether in universities, independent research institutes, or health service settings.

- 15.3 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.
- 15.4 To enhance the spread of innovation across public and private health services, it is proposed 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.
- 15.5 To help embed a culture of continuous improvement, we propose 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.
- 15.6 A permanent, independent national body should be established to lead the way on safety and quality. Its role should include: design and definition, by the end of 2009, of indicators that can be used to monitor the safety and quality of care; and the development of a national patient experience questionnaire, and patient-reported outcome measures.
- 15.7 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:
- 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.
- 15.8 We also propose 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.
- 15.9 We believe that all hospitals, residential aged care services and Comprehensive Primary Health Care Centres should be required to produce an annual public report on their quality improvement and research activities, including reporting on actions arising from investigation of adverse events.