A HEALTHIER FUTURE
FOR ALL AUSTRALIANS

INTERIM REPORT DECEMBER 2008

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National Health and Hospitals Reform Commission

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Australian Government

National Health and Hospitals
Reform Commission

22 December 2008

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

Dear Minister

We are pleased to present the interim report of the National Health and Hospitals Reform Commission (NHHRC).

In the preparation of this report, we have engaged in extensive community and health sector consultation, sifted through hundreds of submissions, sought expert opinion through commissioned discussion papers, and conducted special interest workshops to tap the nation's views on health and health reform.

By international comparison we have a good health system with many strengths to build on. But it is a system under pressure now and facing significant challenges in coming years. The consistent message from our community consultation is that there is a compelling case for health reform to meet the needs of future generations of Australians. People in the community and people working at the frontline in health want change.

Good health is not just about good health care - it requires us all to be active participants in looking after our own health and in supporting the health of our families and communities. In particular the good health of our children must be a priority or we face the damning possibility that our children will be the first generation to have a shorter life expectancy than their parents.

We recognise that healthy choices are not always easy choices for everyone. Governments, businesses, health professionals, communities, families and individuals must work together to make Australia the healthiest country by enabling healthy choices and creating a health and wellbeing system that is safe, fair, efficient, sustainable and people-centred.

In our report, we have emphasised four strategic reform themes:

- **Taking responsibility** – Individual and collective action to build good health and wellbeing – by people, families, communities, health professionals, employers 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** – Better use of people, resources, and evolving knowledge.

Building on the principles and key issues identified in our first report, Beyond the Blame Game (April 2008), we offer clear reform directions in some areas and provide options and suggestions for others, where we feel further discussion would be particularly valuable.

We welcome feedback and discussion on our proposed reform directions as we work toward our final report and implementation roadmap.

Yours sincerely

Christine Bennett

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Chair
National Health and Hospitals Reform Commission

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Overview

The National Health and Hospitals Reform Commission was appointed in early 2008. The title of our Interim Report – **A Healthier Future for All Australians** – reflects the task we have been given: to report on long-term reform for the Australian health care system. Our terms of reference clearly highlight the context for reform:

> *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.*

Australia is not alone in tackling health system reform; most nations are facing similar challenges. While we agree that significant changes are needed to meet these challenges, we also recognise that our health system has many strengths upon which we can build. We are fortunate in having a universal health care system – with publicly-funded access to medical care, public hospitals and pharmaceuticals – a mix of public and private financing and health care provision, and a highly skilled and dedicated health workforce.

Building on these strengths, in this, our Interim Report, we set out directions and proposals for reform of our health care system arising from our consultations and deliberations to date. This overview highlights our key reform directions, with a full list at the end of the overview.

We have identified four themes which encapsulate our directions for reform:

- **Taking responsibility**: individual and collective action to build good health and wellbeing – by people, families, communities, health professionals, employers 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**: better use of people, resources, and evolving knowledge.

The overview is organised around these themes, providing a framework for our messages of reform. But as will become clear in the telling, while the themes provide an organising framework for our areas of health care reform, the themes apply across the health reform areas. Figure 1 gives a 'map' of the overview and the areas discussed.

Figure 1: Themes and health reform areas of the Interim Report of the National Health and Hospitals Reform Commission

Themes	Health reform areas
Taking responsibility	• Building good health and wellbeing into our communities and our lives
Connecting care	• Creating strong primary health care services for everyone • Nurturing a healthy start to life • Ensuring timely access and safe care in hospitals • Restoring people to better health and independent living • Increasing choice in aged care • Caring for people at the end of life
Facing inequities	• Closing the health gap for Aboriginal and Torres Strait Islander peoples • Delivering better health outcomes for remote and rural communities • Supporting people living with mental illness • Improving oral health and access to dental care
Driving quality performance	• Strengthening the governance of health and health care • Raising and spending money for health services • Working for us: a sustainable health workforce for the future • Fostering continuous learning in our health care system

Taking responsibility: individual and collective action to build good health and wellbeing – by people, families, communities, health professionals, employers and governments

Our first theme is the 'golden thread' that connects our report. It is our call to action for all of us – people, families, communities, health professionals, employers and governments – individually and collectively to take responsibility for our health, the health of our children, and the health of Australia. While we are clear that all of us must take care of our health every day and through the changes and transitions of our life, we are also clear that we rely upon the help of our families, communities, health professionals and governments to do so.

We begin our report by considering strategies to build healthier communities and healthier people, as seen from two perspectives:

- a population health perspective, which identifies issues that are relevant to building healthier communities; and
- a consumer empowerment perspective, which considers how individuals can take greater responsibility for their own health.

Building healthier communities

A population health perspective acknowledges the dual importance of building healthy communities – as a priority goal in its own right and as a central input into economic development and poverty reduction. Here we look at two ways of building healthier communities: first, by tackling inequities in health outcomes and access to health care; and, second, through health promotion and prevention activities.

In Australia, with our mix of Medicare and private health insurance, we may believe that there are few barriers or inequities to gaining access to health care and that good health is evenly distributed across our population. While the appalling health status of Aboriginal and Torres Strait Islander peoples provides the most clear-cut repudiation of that position, there are also major disparities in health outcomes and access to health services for other population groups in our community, including people with a mental illness, people with a long-term disability, people living in socio-economically disadvantaged and remote areas, and people from other countries, with other languages and other cultures.

Against this background, we make a clear statement of support not only for our universal health system, but also for additional assistance for groups whose health outcomes and access to health services are worse than others. Thus, our first reform direction states:

> *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.*

A precursor for action on health inequity is that the issue becomes visible. We have two proposals for increasing awareness and understanding of health inequities:

- public reporting by governments, private health insurers and individual health service providers on the health status, health service use and health outcomes of population groups who are likely to be disadvantaged in our communities; and
- the preparation of a regular report that tracks our progress as a nation in tackling health inequity.

Many factors contribute to building healthier communities. Over and above our use of health services and our personal health behaviours, social and economic factors and the built environment play a strong role in influencing the health of our population. Access to employment, education, early childhood care, housing, clean air, and safe food and water contribute to our health.

We believe it is important to match national action on social determinants and health inequity with local participation and action to tackle problems that influence the health of our local communities. 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.

Our second approach to building healthier communities is through building health promotion and prevention capacity at a national level. We highlight three elements to do this.

First, we propose that governments commit to establishing a rolling series of ten-year goals for health promotion and prevention, commencing with Healthy Australia 2020 Goals. The goals would 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.

Second, we propose the establishment of an independent national health promotion and prevention agency. A national health promotion and prevention agency would:

- have a diverse board to promote broad take-up and participation in the health promotion and prevention agenda;
- have a broad scope – advising across portfolios and sectors, and reporting to the Prime Minister and the parliament; and
- have a range of functions, including building the evidence base for the value of health promotion and prevention; leadership, development and management of the proposed ten-year goals; undertaking social marketing and educational campaigns; and leading cross-sectoral action on health promotion and prevention.

Our third element for building health promotion and prevention capacity is about financing prevention. Currently, there is no readily identifiable funding mechanism for prevention and health promotion, partly because we do not have a systematic process to assess the evidence on prevention interventions and health promotion.

As a basis for improved funding mechanisms, we propose that the national health promotion and prevention agency would collate and disseminate information about the efficacy and cost effectiveness of health promotion and prevention interventions.

Businesses and employer groups have also become increasingly engaged in health promotion and prevention. This makes sense given the close relationship between a healthy workforce and economic productivity. At the level of individual businesses, the traditional focus of workplace health on occupational health and safety issues is expanding to include new programs targeting wellness, health promotion, risk screening and self-management for workers with chronic diseases.

We support the delivery of wellness and health promotion programs by employers and private health insurers, and suggest that any existing regulatory barriers to increasing the uptake of such programs should be reviewed.

Encouraging people to take greater responsibility for improving their own health

Good health is a personal, as well as a collective, responsibility. Research by the Australian Institute of Health and Welfare shows that 32 per cent of the burden of disease in Australia is due to seven risk factors which can be reduced or prevented by lifestyle and personal behaviour – factors such as smoking, obesity, physical inactivity, excess alcohol consumption and poor nutrition. As the National Preventative Health Taskforce highlights in its recent Discussion Paper:

> *Ultimately, it is communities, families and individuals who must change behaviours if we are to become a healthier nation.*

But, for many people, healthy choices are not easy choices. People have different capacities to take personal responsibility, with many factors affecting the extent to which people can make meaningful choices about their health behaviours.

Health literacy is one of the major levers that can be used to help people take greater responsibility for their own health – a higher level of health literacy is associated with better health outcomes. Health literacy is defined by the Australian Bureau of Statistics as 'the knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy'.

Three out of every five Australian adults lack basic proficiency in health literacy – they do not have the skills to manage their health and health problems. To ensure higher levels of health literacy in the coming generations, 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 would apply across primary and secondary schools.

There is also a need for life-long learning to support people in making informed choices about their health. There are many channels by which people continue to learn and acquire information on health throughout their lives. We encourage all relevant groups – 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.

We also looked at the use of financial incentives as a lever for encouraging greater personal responsibility for health. Research on the effectiveness of financial incentives has found that financial incentives can be effective in increasing the uptake of preventative health measures, but that they work best when they are targeted to relatively simple one-off interventions (such as immunisation) and are used to reward positive behaviour rather than applied as a financial penalty.

Connecting care: comprehensive care for people over their lifetime

In thinking about the importance of connected, comprehensive health care for people and their families – the second theme in our Interim Report – we have adopted a life course approach. A life course approach emphasises that health develops and evolves over an individual's lifetime. It calls for a more comprehensive and holistic approach to optimising health development, with a greater focus on prevention and health promotion. It organises care around an individual's changing health risks and needs over time and during specific life stage transitions. Another way of saying this is that people need to be able to access the right care, in the right place, at the right time – over time.

Australia is fortunate in having a universal health care system, with publicly-funded access to medical care, public hospitals and pharmaceuticals. But it needs strengthening as the basis for connected, comprehensive care for people over their lifetime, and there are gaps in services.

In the Interim Report, we have focused on completing and bridging the continuum of care to serve people and families, discussing six ways to build a better connected, comprehensive health care system (Figure 2). Taken together, the set of six proposals aims to strengthen the care continuum for individuals and their families – from the beginning to the end of life through the significant stages and transitions – with primary health care as the foundation. In addressing these issues we take with us the message of our first overarching theme: the health care system must be rebalanced with a greater focus on prevention and health promotion, and on sustaining people's health and wellbeing throughout their lives.

Figure 2: Building a better connected, comprehensive health care system

- Creating strong primary health care services for everyone
- Nurturing a healthy start to life
- Ensuring timely access and safe care in hospitals
- Restoring people to better health and independent living
- Increasing choice in aged care
- Caring for people at the end of life

Creating strong primary health care services for everyone

Transforming and strengthening primary health care is essential for the provision of connected, comprehensive health care for people and their families.

Primary health care covers services in the community accessed directly by consumers. It includes primary medical care (general practice), nursing, community health services, pharmacists, Aboriginal health workers, physiotherapists, podiatrists, dental care and all other registered practitioners. It also covers specialised services such as alcohol and drug treatment services, sexual and reproductive health services, young people's services, school health, and maternal and child health services.

Primary health care must be the foundation of the health care system, also providing an accessible gateway to other services. It must be responsive to the changing health needs of people throughout their lives, ranging from:

- child and family health services to promote early childhood development and wellbeing;
- community mental health services to help young people through the difficult adolescent period;
- coordinated care for people with chronic diseases; and
- support for frail older people to remain living in their own homes.

Strong primary health care must also drive quality performance through ensuring the 'right care in the right place', including by reducing avoidable hospital visits and admissions through a focus on early intervention and supported self-management.

Consistent with our first theme of the need for individual and collective action to improve health, our report discusses a number of proposals to transform primary health care that call on people, families, health professionals and governments to take responsibility. In this overview we focus on three: national leadership, establishment of Comprehensive Primary Health Care Centres, and voluntary patient enrolment for people who need a range of services.

We first propose that the Commonwealth would have responsibility for all primary health care policy and funding. The aim is to provide national leadership for transforming, strengthening and integrating primary health care.

The current funding arrangements make it difficult to achieve the goals of connected, comprehensive primary health care. While the Commonwealth is the major funder of primary health care (particularly through the Medicare Benefits Schedule (MBS)), there is a wide range of programs and services with a multitude of funding arrangements from the Commonwealth and state governments.

Single responsibility for funding primary health care would give clear responsibility and accountability to the Commonwealth Government to formulate a coherent national primary health care policy with identified goals, outcomes and strategies, supported by adequate funding.

Our second proposal is for the Commonwealth Government to encourage and actively foster the establishment of Comprehensive Primary Health Care Centres in most local communities. To deliver better connected, comprehensive primary health care will require health professionals to play a role, through establishing and joining larger primary health care services. Although general practices have been growing in size, about 40 per cent of practices still have four or fewer general practitioners.

Comprehensive Primary Health Care Centres could:

- provide a range of services to become one-stop shops for medical and non-medical services including general practitioners, secondary care, diagnostic services, family and child health services, nursing and other health professionals;
- have the skills and facilities for urgent care and be open extended hours;
- have agreed protocols with local hospitals for the swift transfer of patients who require emergency care, specialist assessment or admission;
- have established arrangements with local home and community care providers to ensure coordinated care to clients and to avoid unnecessary hospitalisation; and
- enter into arrangements with local residential aged care facilities to provide visiting and on-call medical services to residents.

We suggest that the establishment of Comprehensive Primary Health Care Centres should be encouraged through a range of mechanisms, including the offer of initial fixed capital grants from the Commonwealth Government on a competitive basis.

Our third proposal for transforming primary health care speaks to people and their families. We want young families and people with chronic and complex conditions – including people with a disability and those with a long-term mental illness – to have the option of enrolling with a single primary health care service to improve continuity and coordination of care and access to multidisciplinary care.

In general, to optimise health and wellbeing, people with chronic and complex care needs require continuity of care over time, from health care professionals who are familiar with the history of their condition or conditions and their treatment. Similarly, families with young children benefit from continuity of care, particularly during the early years.

Under proposals to encourage continuity of care, primary health care services would receive additional grant funding in proportion to the number of people enrolled, the chronic conditions or particular care needs that those people have, and the outcomes achieved. Services may use the funds for a range of initiatives; for example, to:

- employ nurses and other health professionals to provide a broader range of services;
- appoint non-clinical support staff to assist in coordinating people's care; and
- acquire infrastructure, such as clinical information management systems, to support care delivery.

Finally, in our Interim Report we argue that creating a robust and integrated primary health care service will require the implementation of a person-controlled electronic personal health record. Across Australia's range of community- and hospital-based health care settings the sharing of information is limited, fragmented or non-existent. This results in high dissatisfaction from patients, exasperation from clinicians, adverse events and sub-optimal care.

An electronic health record that can be accessed – with the person's agreement – by all health professionals and across all settings is arguably the single most important enabler of truly person-centred care. It is one of the most important systemic opportunities to improve the quality and safety of health care in Australia. We will explore the prerequisites and incentives to allow us to reach this goal in our final report.

Nurturing a healthy start to life

Seen through the lens of the developmental nature of health, the early years provide the foundation for a person's health and wellbeing in life. Improving the health and wellbeing of children is important both because of the intrinsic value and because doing so will improve the health of the population as young people age into adulthood. Many adult health conditions – including major public health problems such as obesity, heart disease, diabetes and mental health problems – have their origins 'in utero' and in childhood.

Investments in early childhood development are among the most powerful that a nation can make. They enable more children to grow into healthy adults who can make a positive social and economic contribution to society while reducing the escalating chronic disease burden in adulthood. For example, early identification and intervention can prevent entirely or reduce the magnitude of many disabilities, developmental delays, behavioural problems and physical and mental health conditions. Investments in early childhood can also be a powerful force for equity, with interventions having the largest benefits for the most disadvantaged children.

Although the health of Australian children has improved over the past few decades, there are concerning levels of childhood mental health and socio-behavioural issues, and increases in chronic complex diseases, obesity and physical inactivity. Furthermore, the health of Aboriginal and Torres Strait Islander children is still significantly poorer than that of other children.

Tackling the root causes of many of the most prevalent children's health issues requires new ways of working across health, education, family support, and community development programs. While we acknowledge the need for such a comprehensive approach, within the scope of this report we focus on the health system.

The early childhood health system has a number of shortcomings that limit its effectiveness, including significant inequities in access to services (particularly for children in rural and remote areas) and fragmentation of service delivery. The system is not responsive to children with complex needs from vulnerable families, and often fails children with a disability or developmental concerns, who have to navigate a complex system and often experience long waiting times and poor continuity of care. There is also variable access across Australia to specialist teams for children with chronic or severe health conditions.

We propose an integrated strategy for the health system to nurture a healthy start to life for Australians. The strategy has a focus on health promotion and disease 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.

Our strategy for a healthy start is 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.

The strategy would begin 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, there would be targeted care for women with special needs or women at risk, such as home visits for very young mothers.

In the early childhood period between birth and eight years of age, universal child and family health services would 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 child and family health services identify a health or developmental issue or support need, the service would 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.

Ensuring timely access and safe care in hospitals

Hospitals provide the most complex and costly care to the sickest people in our community. They are also where most babies are born, and where many people die. They are the source of emergency care when people are suddenly or severely ill and, when no other care is available, people often turn to hospitals. They are one of the major settings for clinical education of the present and future generations of health care professionals. They undertake world-class research that is used to provide better health care treatment and improve outcomes for people.

About 40 per cent of all health expenditure in Australia is spent on hospital care. Expenditure on hospitals is projected to be the fastest growing element of health expenditure over the next decades. It is crucial that we make the best and most efficient use of these vital and expensive services.

There are more criticisms and concerns about hospitals than about any other part of health service delivery. We know that our hospitals are under severe pressure, directly influencing their ability to provide safe, high quality, accessible and timely care to people.

Many of the problems besetting hospitals arise from other health care services. They affect hospital performance but are outside the direct control of hospitals, such as lack of timely access to primary health care, sub-acute care and aged care. These problems and our proposals to address them are discussed in the relevant sections of the overview.

Regarding issues directly related to hospitals, our Interim Report puts forward a range of proposals to improve hospital care, covering service delivery, funding, accountability for performance, planning and clinical leadership. In this overview we focus on three areas: improving access to emergency care and to elective procedures and treatment, and better hospital planning.

Across all categories of urgency, only 70 per cent of people – and less than two-thirds of urgent patients – presenting to public hospital emergency departments are seen within clinically appropriate times.

The most critical issue for the performance of emergency departments in major public hospitals is 'overcrowding', where there are more people in an emergency department receiving treatment (not waiting for care) than can properly be looked after by the available staff. Overcrowding is directly related to a hospital's capacity to admit people who need inpatient treatment within a reasonable time from the emergency department. There is evidence that overcrowding is strongly associated with inpatient occupancy of 85 per cent or more.

Rather than prescribing particular bed management practices, we propose that funding arrangements for hospitals with a major emergency load should be based on a combination of activity-based funding and fixed grants. The fixed grants would fund availability of the emergency department service and maintain the necessary capacity to admit people from the emergency department promptly.

We also propose development and adoption of National Access Targets for emergency care. Under the National Access Targets, a share of the funding available to public hospitals would be payable as a bonus and linked to meeting, or improving performance towards, the Access Targets.

The other problem of timely access to hospital care that receives public attention is the delay in 'elective' procedures for public patients. The term 'elective' refers to admissions that can be delayed for at least 24 hours. These are sometimes also referred to as 'planned' or 'booked' admissions. The term elective has connotations that the procedures or treatments are optional or a matter of choice. However, most elective procedures or treatments are essential; for example, joint replacements to remedy chronic pain and maintain mobility. In some instances elective procedures can be critical to people's survival; for example, diagnostic procedures to confirm whether someone has cancer.

Similar to access to emergency care, we believe that access times for elective – or planned – procedures or treatments can be improved by measuring performance and introducing financial incentives in the form of bonus payments for hospitals to achieve access benchmarks. To set benchmarks, we propose development and adoption of National Access Guarantees for planned procedures and treatments. The Guarantees would be developed incorporating clinical, economic and community perspectives through vehicles like citizen juries.

We have so far discussed separately two problems of timely access to hospital care: access to emergency departments and for planned procedures. These are often competing objectives for hospitals, as improving performance on one can come at the expense of performance on the other. A critical issue for public hospitals is the need to balance provision of emergency care and planned admissions.

One approach which can be very effective for the delivery of both planned and emergency care is to have specialised planned procedure hospitals or centres. This would separate completely the facilities and staff responsible for providing planned procedures from those providing emergency care. These can be 'hospitals within hospitals' – that is, specialised planned procedure units can be established as separate facilities as part of a larger hospital. Alternatively, particular hospitals in a region can be dedicated to planned procedures.

We propose that consideration be given to further planning and development of specialised facilities for planned procedures in Australia's major cities.

Restoring people to better health and independent living

Sub-acute care provides the 'glue' that connects acute care provided in hospitals with community care provided in people's homes. It includes services such as rehabilitation, geriatric evaluation and management, new programs such as Transition Care and other 'step-up' or 'step-down' programs. These services work hand-in-glove with other services such as respite care, community nursing, and home and community care services. Sub-acute services will often involve multidisciplinary teams, with strong input from a range of specialist allied health staff.

Sub-acute care can help to improve functioning and independent daily living, reduce or slow further decline in health status, reduce unnecessary visits to hospitals, reduce the amount of time people spend in acute hospitals, and prevent premature admission for older people to residential aged care facilities.

Many parts of Australia have limited or poorly developed sub-acute care, representing a significant 'missing link' in the care continuum. This service gap seriously erodes the effectiveness of other services, particularly acute hospital care, as well as causing poorer outcomes for patients. An ageing population and increasing chronic disease will further strain our already under-developed sub-acute services.

We want to increase access to sub-acute care by directly linking funding to the delivery and growth of sub-acute services. We support a dual approach to funding, comprising a mix of activity-based funding (including the cost of capital), with the use of incentive payments related to improving outcomes for patients.

We also propose that clear targets to increase the provision of sub-acute services should be agreed by June 2010, with incentive funding available to drive the expansion. The 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. As well, investment in sub-acute services infrastructure should be one of the top priorities for the Health and Hospitals Infrastructure Fund.

Increasing choice in aged care

The theme of connecting care strikes a number of chords in the area of residential and community aged care. We hope that aged care connects well with the needs of older people; we hope that aged care connects well with a person's family and support networks; and we hope that aged care connects well with other health services, particularly prevention, health promotion and primary health care, as well as hospital care. In this overview we focus on two objectives: meeting the future demand for aged care, and enabling older people to have greater choice and more control over their care.

Aged care services must be more responsive to the needs of older people. Central to this is ensuring an increased supply of high quality, efficiently delivered aged care.

If the Commonwealth's approach of regulating supply to meet a target ratio continues, the number of residential aged care places will have to increase by more than 50 per cent by 2020. This will require substantial capital investment in residential care. Aged care providers maintain that access to adequate capital funding requires the capacity to charge accommodation bonds for people entering high care, especially for not-for-profit providers that lack access to other methods of capital raising such as issuing shares.

The regulation of aged care, and in particular restrictions on the number of aged care places, limits choice for older people, reduces competition between providers, results in high occupancy and correspondingly low vacancy rates, and so limits incentives for providers to be entrepreneurial and responsive to older people and their families. High occupancy rates also contribute to the numbers of older people who remain in hospital for want of an aged care place that meets their needs. We propose two changes to the current arrangements for the regulation of supply.

First, we propose lifting the restriction on the number of places while retaining control over the number of people receiving subsidies at any one time. Providers of aged care would still need to meet existing criteria to be eligible for government support, including being an approved provider under the Aged Care Act, and their facilities being accredited. However, if they meet these criteria, approved providers could offer as many places as they wished.

Under our proposal, the number of people at any one time receiving subsidised aged care would be limited to the target ratio for provision. This would be done by Aged Care Assessment Teams having a maximum number of approvals for care for people living within an aged care planning region. The maximum number of approvals would be calculated on the basis of a target ratio per 1000 older people in the same way as the current planning ratio for aged care places. This approach would open up aged care provision to greater competition between providers for those who are eligible for subsidised care.

Second, we propose changing the target ratio for provision. The current ratio for Commonwealth aged care provision is based upon the population aged 70 or over. The use of this population dates back some decades, when people had shorter life expectancies. We suggest that the population aged 85 or over would be more appropriate as it is a better measure of need for aged care, more closely reflecting the age of those who use Commonwealth aged care.

Putting the two changes together would change 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**. The aim is to link funding more directly to people rather than places, and to those who are most likely to need care.

Removing restrictions on the number of aged care places in line with our proposed reform should result in increased competition in the provision of aged care, which may extend to price competition. This may enable some cautious relaxation of current constraints on charges for residential care accommodation.

Under the existing circumstances of supply and regulation of aged care, we support the view that accommodation bonds in high care should be restricted. However, 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 limits on the number of places has resulted in sufficient competition in supply and price.

We turn now to our second aged care issue and consider ways to enable older people to have greater choice and more control over their care. The current program design and administration of multiple community and residential aged care programs distort older people's choice of care, restrict their control over their care, and hinder their continuity of care when moving from one kind of aged care to another. We propose a series of changes which would:

- consolidate all aged care programs under the Commonwealth Government;

- introduce streamlined, consistent assessment for eligibility for care across all aged care programs, so that people would only have to undergo a single assessment process;
- change subsidies for community care so that they better match objective measures of need, and better align with subsidies for residential aged care; and
- harmonise fees (excluding accommodation costs) for community and residential care to encourage people to choose their care based upon the level of care they require and not upon the costs they will face.

This series of changes would open up options for consumer-directed care. Older people eligible for community care would be able to determine how to use the resources allocated for their care and support, the level of which would be more closely related to their need for care. In addition, having an approach to assessment for a care subsidy that is similar across community and residential care would provide a better basis for people to opt for community care rather than residential care. This might also enable a wider range of accommodation choices for people needing care, including, for example, through combining a budget allocation for consumer-directed community care with retirement village accommodation.

Caring for people at the end of life

End of life care is care provided to people who are living with a condition that will ultimately cause or contribute to their death. Death can come in many ways and at any age, so our approach to end of life care needs to be able to respond to the different timings and ways in which people die.

We face new challenges in providing end of life care. Some of these are related to changes in disease patterns (such as more people with dementia). Other challenges include ensuring that palliative care services are available to all groups who would benefit from such care, and that these services are readily accessible in the community and in people's homes.

We emphasise throughout our report that primary health care must be the foundation of the health care system. We propose building the capacity and competence of primary health care services to improve the provision of generalist palliative care support for people dying. This will require greater educational support and improved collaboration and networking with specialist palliative care service providers.

The direct support of specialist palliative care services is needed for a small number of dying people. But it is sometimes only available at a relatively late stage, and it is not consistently available for all conditions for which it would be helpful. 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 and people at home in the community.

Finally, 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. There is good evidence that advance care planning can help people have greater choice and more control over their dying, with their wishes respected about the type of care they wish to receive and where they wish to die.

Facing inequities: recognise and tackle the causes and impacts of health inequities

There is an urgent need to face up to and tackle inequities in health status and health outcomes and in access to health services for many groups in our community. In talking about equity, we want to be clear that equity does not necessarily mean 'equal' access or 'equal' care for all people. When we consider, for example, the 17-year life expectancy gap between Aboriginal and Torres Strait Islander people and other Australians, it is clear that providing 'equal' access to services or 'equal' levels of funding will simply not be enough because the need is 'unequal'. The level of resources needs to be proportionate to the greater health problems and disadvantage.

In this section of our Interim Report, we propose reform directions to tackle inequities affecting Aboriginal and Torres Strait Islander people, remote and rural communities, people with mental health conditions, and people with poor access to dental services. We address general issues of health inequity and issues related to inequity of access for people with a disability and people who face financial barriers in other sections of the Interim Report.

Closing the health gap for Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples of Australia are the oldest continuing cultures in human history. As the first Australians, they deserve special recognition and respect.

The 'closing the gap' campaign is about squarely facing the inequity of the continuing poor health of Aboriginal and Torres Strait Islander people, which is starkly reflected in the 17 year gap in life expectancy between Indigenous and non-Indigenous Australians. The campaign is about recognising and tackling the causes and impacts of this gap.

We believe that this is achievable – public awareness is high, and the impetus for action is strong. We propose reform directions to close the health gap and to build a health system that is responsive to the needs of Aboriginal and Torres Strait Islander people. The reforms include:

- national leadership, with the Commonwealth Department of Health and Ageing leading the inter-sectoral collaboration that will be required to tackle the health and social determinants of the gap;
- an investment strategy that is proportionate to health need, the cost of service delivery and the achievement of desired outcomes. A substantial increase on the current expenditure would be required to close the gap;
- building and expanding the organisational capacity of Aboriginal Community Controlled Health Services to provide and broker comprehensive primary health care services – these community controlled health services contribute significantly to reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health outcomes;
- the accreditation of health services, requiring core Indigenous modules to ensure clinical quality and culturally safe services; and
- implementing a comprehensive national strategy to recruit, retain and train Aboriginal and Torres Strait Islander health professionals at the undergraduate and postgraduate level. This would include setting targets for education providers, with reward payments for achieving graduations; funding better support for Aboriginal and Torres Strait Islander health students; and strengthening accrediting organisations' criteria around cultural safety.

In this overview we focus on explaining our most significant reform direction – a new approach to purchasing health services for Aboriginal and Torres Strait Islander people.

Purchasing may seem like just a bureaucratic process. But purchasing determines the way funds flow to health services in ways that can deliver improved outcomes. Purchasing arrangements can be used strategically to support quality and access by funding services (or not) under required conditions, thereby shaping service provision and strengthening accountability for health outcomes.

We propose one approach to this could be the establishment of a National Aboriginal and Torres Strait Islander Health Authority (the Authority) to purchase services specifically for Aboriginal and Torres Strait Islander Australians and their families. The Authority would purchase health services from accredited providers with a focus on outcomes to ensure high quality and timely access. Services could be purchased from Aboriginal Community Controlled Health Services, mainstream primary health care services, hospitals and other services. The Authority would ensure that all purchased services met set criteria including clinical standards, cultural appropriateness, appropriately trained workforce, data collection, and performance reporting.

Underpinning the establishment of the Authority would be the acknowledgement that improvement in Aboriginal and Torres Strait Islander health is important to all of Australia and that there is a need for consolidated, affirmative action to meet the needs of Aboriginal and Torres Strait Islander peoples.

We have modelled the National Aboriginal and Torres Strait Islander Health Authority on the approach taken by the Department of Veterans' Affairs to secure the best health outcomes for the veteran community. Acknowledging the special health needs of this community, the Department is charged with ensuring they are met by providing access to medical, hospital and allied health care services for veterans. It does this through contracting with hospitals and health care providers, with strong quality assurance mechanisms.

We acknowledge that our proposal for an Aboriginal and Torres Strait Islander Health Authority would significantly change the way health services are delivered to Aboriginal and Torres Strait Islander people who choose to participate. That is the point. Along with all Australian governments we recognise that 'more of the same' will not close the health gap. A new approach is required to drive improvement in the quality and responsiveness of the whole health system for Aboriginal and Torres Strait Islander people.

Delivering better health outcomes for remote and rural communities

Remote and rural areas and the people who live in them are important to Australia's economic base, food security and our national identity. But our natural assets of wide open spaces and geographically dispersed populations are also our greatest challenges in equitable health services provision.

Nearly one-third of Australians live in remote and rural areas. They generally have poorer health than other Australians, with shorter life expectancy, higher rates of accident and injury and of some chronic diseases and preventable cancers. They also, however, have lower rates of certain medical treatments. For example, death rates from heart disease are 40 per cent higher in rural and regional areas than in metropolitan areas but coronary artery bypass grafts are 30 per cent lower. People who face special difficulties in accessing health care – including Aboriginal and Torres Strait Islander people, people with mental illness and people from lower income families – are doubly disadvantaged if they live in remote and rural areas.

To tackle health inequities in remote and rural areas, we have put forward proposals on funding, service delivery and workforce. In this overview we focus on four key proposals.

First, we argue that more equitable health care requires more equitable distribution of funding resources. In order to deal with disadvantage, disadvantage needs to be factored into the funding formula across primary health care for remote and rural areas. To redress the current inequitable funding basis, we propose that funding be provided to remote and rural communities based on adjusted average per-capita primary health care spending.

Second, we propose an expansion of the multipurpose services program to towns with catchment populations of approximately 12,000. The multipurpose services program is a joint Commonwealth and state model of service delivery that aims to help small remote and rural towns tackle some of the challenges they face in health and aged care delivery. The strength of the program is its capacity to adapt the provision of services to the circumstances of diverse communities, through the flexible expenditure of funds across health and aged care programs.

Third, in the Interim Report we argue for more effective and better funded avenues for bringing health care to people in remote and rural areas, and in bringing people from remote and rural areas to health care.

Here we highlight two:

- Telehealth and telemedicine are used in Australia as an avenue for bringing health care to people in remote and rural areas, but they are not being used to their full potential. With limited exceptions, current Medicare arrangements require that the patient be present for a consultation and that only one provider can bill for a service with the same patient at the same time. Under these arrangements, if a telehealth consultation with a metropolitan specialist is arranged and the rural specialist or general practitioner accompanies the patient, only one of the doctors can bill for this service. These outmoded funding arrangements need to be changed.
- All state and territory governments provide a patient travel and accommodation assistance scheme to help people in remote and rural areas to access specialist medical appointments and treatment. But there are significant differences among the jurisdictions in eligibility and operation. 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.

Finally, we acknowledge the great challenges in building and maintaining a health workforce in remote and rural areas, and the impact this has on access to care for people living in these areas. One point is clear: health professionals who are from remote or rural areas or who undertake their education and training in remote or rural areas are more likely to work in those areas. We therefore propose that a higher proportion of new undergraduate and postgraduate places across all health professional 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.

Supporting people living with mental illness

Mental health enables us to fulfil our capabilities, have strong and caring relationships with our families and friends, cope with the normal stresses of life, work effectively, and participate in our communities.

Sadly, though, mental illness is common, with the burden of mental illness greatest in late adolescence and early adulthood. With appropriate diagnosis, treatment and support, however, most people with mental illness can recover and function normally.

But an estimated 65 per cent of people who need mental health care go untreated. Australia's mental health services are inadequate and incapable of meeting present, let alone future, needs. Although reforming Australia's mental health services will require additional investment, this is not the most significant change that is required. The most important reform needed is to reorient mental health expenditures towards prevention, and the treatment and supports people with mental illness need.

Our Interim Report particularly addresses issues around better access to health and community services. More than any other clinical condition, mental health disorders require a unique approach to care provision, with a particular focus on integration and partnership, both for the individual and the health service team. Care also needs to be provided across a continuum, allowing the consumer to enter and exit the system easily. To achieve this, a fundamental shift in service provision is required – a shift to community-based and hospital in-reach care.

Adolescents and young adults are particularly reluctant to seek treatment or assistance for mental disorders. Community-based programs which successfully integrate services and focus on early identification and treatment for young people are essential. Some already exist, bringing together private medical, psychological and psychiatric practitioners alongside mental health and drug and alcohol workers and vocational assistance providers in one central location.

Mental health practitioners and experts support this type of model as it is youth-friendly, easily accessed and focused on identification and appropriate early intervention for the range of mental health problems affecting young people. It also provides a platform for referral to specialist services for particular disorders – for example, personality disorders, eating disorders, and early psychosis – where evidence shows early diagnosis and treatment improves outcomes.

We support increased access to this model, and propose that a youth-friendly community-based service that provides information and screening for mental disorders is rolled out nationally. The chosen model should draw on evaluations of current initiatives in this area.

Psychosis is a particularly debilitating mental illness that often strikes in adolescence or early adulthood. With appropriate treatment the majority of young people who experience a psychotic illness will recover. The earlier that treatment is started, the quicker and better the recovery. We put forward two proposals to improve access to health care for people with psychosis.

First, we propose that the Early Psychosis Prevention and Intervention Centre (EPPIC) model be implemented nationally so that early intervention in psychosis becomes the norm. In this model, case managers and clinical experts work closely with a young person and their family to facilitate early treatment and understanding of psychosis, and to reduce disruption to the young person's life. Early intervention delivers better health and social outcomes for those affected, as well as savings to the health system, particularly from reduced hospitalisations.

Second, we propose that every acute mental health service should have a rapid-response outreach team for those individuals experiencing psychosis. An acute psychotic episode can be extremely difficult to manage, for all involved. Often, people suffering from a psychotic episode end up at an already over-stretched and ill equipped emergency department of a public hospital due to lack of alternatives. A rapid-response outreach team that is part of hospital-based mental health services enables those experiencing psychosis to be treated effectively away from an emergency department environment.

More generally, for severely mentally ill people we propose that every hospital-based mental health service should be linked with a multi-disciplinary community-based service that supports 'stepped' prevention and recovery care. This would provide a two-way bridge between primary health care services and hospital services. In practical terms, this is about investing more in mental health services in primary health care and sub-acute settings, instead of relying unduly on acute or hospital care.

Improving health outcomes for those with mental disorders requires more than better access to quality health care. It requires seriously coming to grips with and providing for the multitude of needs that this group has. Social supports such as income support, assisted housing and education and training are essential to adequately provide for the needs of those suffering from severe mental illness.

Stable accommodation is particularly important for people with a mental illness, providing a secure environment for recovery and prevention. We propose that all state and territory governments provide people suffering from severe mental illness with stable housing that is linked to specialist support services. Associated with this, 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, it is clear where the person will reside, and someone appropriate at that location is informed.

Improving oral health and access to dental care

Despite the introduction of universal insurance for medical services, pharmaceuticals and treatment at public hospitals, Australia has not been able to deliver equitable access to dental care. The separation of oral health – the condition of our mouth, our teeth and our gums – from general health is embedded in the current organisational and funding arrangements for health.

Governments contribute less than 20 per cent of all spending on dental services, health insurers contribute about 14 per cent, and individuals bear two-thirds of the total cost directly as out-of-pocket payments. The significant out-of-pocket costs associated with dental care create access barriers for many of the most disadvantaged in our community.

Poor oral health affects our overall health, wellbeing and quality of life:

- Loss of teeth impairs eating, leading to reduced nutritional status and diet- related ill-health, particularly for children and older people.
- Poor oral health is linked with other health conditions such as cardiovascular disease, preterm birth and low birth weight, hepatitis C, and otitis media.
- Oral diseases create pain, suffering, disfigurement, disability and in some cases death.

Many Australians cannot afford private dentists, particularly those without private health insurance. In rural and remote areas there is also a great shortage of private dental services. But there are also long waiting times for access to public dental care. Current estimates indicate that there are about 650,000 adults on waiting lists for public dental services across Australia, with an average waiting time of 27 months. Services provided through public dental services are predominantly for emergency care such as extractions. There is limited focus on prevention and restorative work.

The absence of early intervention is costly and unproductive. Common oral diseases such as tooth decay, gum disease and oral cancers are preventable with early detection and treatment. There were an estimated 50,000 avoidable hospital admissions arising from preventable dental conditions in 2004–05.

To 'face the inequities' of access to dental care, to bring oral health within the health care system, we propose a bold reform: that Australia should have a scheme for universal access to dental care, regardless of ability to pay.

Under the new 'Denticare Australia' scheme all Australians would be covered for preventive, diagnostic and restorative services, including extractions and dentures. The scheme would be funded by an increase in the Medicare Levy of 0.75 per cent of taxable income, the most equitable approach to raising the additional funds required to achieve universal coverage. The extra Medicare Levy funding would be combined with all existing funding by governments (Commonwealth and states) to create the funding pool used as the basis for 'Denticare Australia', which would be administered by Medicare Australia.

How this would work at the level of individuals and families is that:

- Everyone eligible to pay the Medicare Levy would pay an extra 0.75 per cent of taxable income towards a universal dental scheme ('Denticare Australia').
- This levy would replace existing premiums paid for private dental health insurance covering preventive, diagnostic and restorative services and most out-of-pocket costs for these dental services.
- Everyone, regardless of whether they have private health insurance for other health services, could choose either a dental health plan from a private health insurer or to rely on expanded public dental services funded by 'Denticare Australia'.
- For people choosing a private dental health plan, 'Denticare Australia' would pay the premium for that plan for them from the new funding pool. At the outset, the premium payment would be set at a level so that individuals and families were covered for about 85 per cent of the current costs of private dental services covered under the package.
- 'Denticare Australia' would also provide additional funding for public dental services to expand their availability for people choosing to rely on them. There would be no out-of-pocket costs for people using public dental services; however, there might still be some waiting times to access care.

The premium paid by 'Denticare Australia' to a private health insurer for each person choosing their dental plan would be 'risk adjusted' – that is, it would be higher for people likely to require more dental services and lower for people likely to require fewer. Private health insurers could still offer coverage for 'elective' dental services such as orthodontics, cosmetic and laser dentistry that are not covered by 'Denticare Australia'.

We estimate that under this proposal:

- 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.

This major change to the funding of dental care would be supported by two strategies to significantly improve public dental services.

First, we need to expand the clinical experience and training of the dental workforce. To do this, we support the introduction of a dental education and residency program – a one-year internship scheme prior to full registration. This would make the clinical preparation of oral health practitioners (dentists, dental therapists and dental hygienists) similar to that of medical practitioners.

Second, we propose the national expansion of pre-school and school dental programs. There has been a 20 per cent increase over the last 10 years in the number of primary school children with tooth decay. These changes have been associated with a decline in access to school dental programs and changing dietary patterns which increase the risk of tooth decay.

Driving quality performance: better use of people, resources, and evolving knowledge

Our fourth theme is about reforming important determinants of quality performance in health care:

- how we govern the health system;
- how we fund health care;
- the skills, expertise and distribution of the health workforce; and
- our research basis and organisational cultures, which underpin innovation, continuous improvement, and quality and safety.

These factors significantly impact on the performance of our health care system, helping or hindering quality and productivity.

Strengthening the governance of health and health care

Governance – or who should 'run' the health system – is without a doubt the single most controversial issue we have been asked to tackle.

In Australia, responsibility for health care is divided between two levels of government, which each have quite different approaches to funding, and quite different relationships to providers. The states and territories are directly involved in providing health services through government authorities, whereas the Commonwealth is predominantly involved in funding health services, many of which are privately provided.

With this separation of responsibilities, no level of government has a detailed understanding of all aspects of the health sector. Each level of government formulates policies in relation to its responsibilities that do not take account of the health system as a whole, or are designed to shift costs onto the other.

For consumers and health professionals, it is fair to say that there is widespread dissatisfaction with the fragmentation of services and difficulties with navigating a complex system. The public does not find it easy to know which government to hold to account for their access to health care and the quality of that care.

A strong message we heard from many consumers and health professionals was a desire for 'one health system'. While this idea means different things to different people, we believe that there is considerable merit in identifying functions that would benefit from being undertaken on a consistent national basis. Irrespective of any other changes to the governance of the health system, we propose that a range of functions should 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 reporting; private hospital regulation; and technology assessment.

Our Interim Report is clear that strong primary health care is the foundation of our health care system. The current split in funding and responsibility weakens the effectiveness of primary health care, distorts priorities and causes problems in service delivery. We propose that the Commonwealth should take responsibility for policy and funding of all primary health care. Again, this should occur irrespective of any other changes to the governance of the health system.

Regarding more fundamental change to the governance arrangements for Australia's health system, we are putting forward three options for further consideration, and on which we welcome feedback.

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

Under this option, the Commonwealth would:

- be responsible for all funding, policy and regulation for primary health care;
- pay to states and territories a hospital benefit per episode of the efficient costs of inpatient and emergency department treatment (set at, say, 40 per cent). Outlays would be limited by the level of expenditure each state or territory would support paying for the balance of the cost of hospital treatment; and
- pay, using a casemix classification, 100 per cent of the efficient costs of delivery of hospital outpatient treatments, according to a budget negotiated with each state and territory.

These arrangements 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. The advantages of this option include:

- Continuing to have both levels of government involved ensures that the states remain accountable to their own populations for health services, and that the potential diversity and innovation that comes with state involvement continues.
- It would strengthen the provision of integrated care by making outpatient care and primary health care the responsibility of the Commonwealth.
- As the Commonwealth will be liable to make a payment for every episode of hospital treatment, it will have an incentive to shape the programs it is responsible for – particularly primary health care and aged care – to reduce demand for emergency department and admitted hospital care.

- A Commonwealth case payment for each admitted patient episode will also drive improved efficiency as the payment will be based on the efficient cost of delivery across all hospitals, public and private.

The option would also involve less disruption to existing roles and responsibilities compared with the other two options outlined below, and thus the implementation and transition risks would be lower.

Nevertheless, the continued involvement of two levels of government would still create challenges for coordination of policies and programs. There would also be new boundaries across which there might still be some tension.

Option B: Commonwealth to be solely responsible for all aspects of health care, delivering through regional health authorities

This option would transfer all responsibility for public funding, policy and regulation for health care to the Commonwealth. The Commonwealth would establish and fund regional health authorities to take responsibility for former state health services, such as public hospitals and community health services. Existing national Commonwealth payments would be retained (such as the MBS, Pharmaceutical Benefits Scheme (PBS) and aged care subsidies).

The key features of this option are:

- Instead of eight sets of legislative and organisational frameworks for health services, there would be single national legislation and a single national approach.
- Regional authorities would be responsible for planning, commissioning and operating an integrated provision of health services for their region.
- Regions would be required to develop three- to five-year regional plans, with clear involvement from health services and the region's community. These plans would identify local priorities for service development and health improvement.
- The Commonwealth would negotiate three-year funding agreements with each regional authority detailing the elements of proposed regional plans for funding.

The advantages of this option include:

- substantial resolution of the 'blame game' between governments, by making one government squarely accountable for all of health and health care;
- an improved capacity to integrate care around people's needs;
- a better basis for a rational allocation of funds across the various programs, with a greater focus across the system on effectiveness of care and innovation; and
- some flexibility in the use of funds by regional health authorities, and the potential to foster local innovation.

However, Option B requires a major shift of funds and management expertise from the states to the Commonwealth with all the attendant risks of major change.

The option also potentially weakens community and electoral accountability and responsiveness by having only the national level of government involved in health and health care. Arguably, state and territory governments are more responsive to the views of their electorate than a national government that has to balance the interests of Perth or Launceston against those of Sydney or the Gold Coast.

It is likely that there would be new tension between regional health authorities and the Commonwealth around the adequacy of funding, and possibly also around the boundaries between the continued national programs (MBS and PBS) and those funded through a regional budget.

Option C: Commonwealth to be solely responsible for all aspects of health and health care, establishing compulsory social insurance to fund local delivery

This option would transfer all responsibility for public funding, policy and regulation for health care to the Commonwealth, with the Commonwealth establishing a tax- funded community insurance scheme under which people would choose from multiple, competing health plans. The key features of this option are:

- All Australians would be required to enrol with a health plan of their choice. Health plans would have no right to refuse an individual.
- The Commonwealth would raise funding via an identified health levy to meet the full costs of the scheme. This funding would be allocated to a health plan of the citizen's choice based on the 'risk adjusted' membership profile of each plan.
- The plans would be required to cover a mandatory set of services, including hospital, medical, pharmaceutical, allied health and aged care.
- Health plans would be free to strike their own arrangements with providers, including entering into preferred provider arrangements.
- Co-payments for mandatory coverage could be limited by regulation.

Key strengths of social insurance are the incentives for health plans to be responsive to the needs of their members and to purchase services in an integrated way to meet those needs. Accountability is strengthened by people's capacity to change to another health plan if they are not satisfied.

Health plans also have an incentive to take initiatives that will improve the health of their members, and to purchase health services with a focus on high quality performance and outcomes.

This approach also provides competitive pressures for innovation and efficiency, with health plans aiming to maximise the cover they can offer to attract more members while maintaining or improving their operating margins.

Potential downsides with social insurance include transactions costs. Relative to Option B, the social insurance option would involve health services having to negotiate arrangements with many different health plans. There may also be additional complexity for consumers trying to establish which health plan will best meet their needs. There will be potential loss of economies of scale currently achieved in the administration of the major national programs.

This option also requires the greatest departure from existing approaches, with all the attendant risks inherent in such a fundamental change.

Raising and spending money for health services

Spending on chronic diseases will dominate the growth of our future health and aged care expenditure. By 2032–33, spending to treat people with Type 2 diabetes is estimated to increase by 520 per cent, for people with dementia by 364 per cent, and for people with respiratory conditions by 205 per cent. In terms of services, if we continue with business as usual, the fastest growing areas of spending will be for acute services, such as hospitals and aged care.

In 2006–07, the most recent year for which figures are available, Australia spent $98 billion – or about 9.5 per cent of gross domestic product – on health and high-level aged care services. Spending is forecast to rise to 12.4 per cent of gross domestic product in 2032–33. Our theme of driving quality performance highlights the importance of ensuring our investment in health and aged care achieves improved health outcomes, efficiently.

We need to change how much, and where, we spend to improve the outcomes from health spending and to contain the upward pressure on health budgets. We contend that this is possible through evidence-based investment in strengthened primary health care services and health promotion and prevention to keep people healthy.

Australia's mix of public and private financing is generally regarded as one of the strengths of our health system. We agree, and want to see the overall balance of spending through taxation, private health insurance, and individuals' out-of-pocket contributions maintained. We are open, however, to options that result in changes to the mix of financing for particular types of health services. For example, we raise concerns about the costs borne by individuals for some health services, such as dental care and aids and appliances.

About one in every six dollars spent on health services in Australia is paid for directly by individuals, comprising, on average, about 5.3 per cent of the household weekly budget. This includes co-payments for services covered by Medicare and costs for some health services that sit outside our universal access programs.

There is currently a 'patchwork' of safety nets and programs designed to protect people from high health costs for certain services. The different eligibility rules and requirements for different services are not compatible with an equitable, high-performance health system. In our final report, we will explore new safety net arrangements that are better integrated and cover a broader range of health costs.

Turning now to approaches to recurrent and capital funding, in our Interim Report we consider the way in which funding is allocated to pay for health services. Different types of approaches to funding health services have different incentive effects. Choices about the allocation of funding need to consider the best type of funding to achieve the particular objectives being sought. Our view is that a mix of different funding models will need to be used across the whole health system.

Generally, however, we propose that incentives for improved outcomes and efficiency should be strengthened in health care funding arrangements. This will involve greater use of:

- activity-based funding (for example, casemix funding), which tends to drive greater efficiency and productivity;
- payments for care of people over a course of care or period of time, particularly in funding for primary health care; and
- payments to reward good performance in safety and quality, patient outcomes and timeliness of care, across all settings.

In particular, we support the use of activity-based funding as the principal mode of funding for both public and private hospitals, where the level of funding is linked to the volume of services hospitals provide using casemix classifications (including the cost of capital). Emergency department services should be funded through a combination of fixed grants (to fund availability) and activity-based funding.

Activity-based funding requires an understanding of how much of what kinds of services will be provided, and what the efficient cost of providing them is. It rewards the efficient and puts the less efficient under pressure to improve. It provides a powerful incentive for hospitals to perform as efficiently as possible, maximising services provided for the available funds.

Another key strength of activity-based funding is that it can be used to pay for important hospital outputs other than treatment services. For example, a very important function of many hospitals is teaching health professionals. Activity-based funding can be used to define and pay for teaching, ensuring that this crucial function is appropriately funded and carried out.

Moving now to the issue of capital costs, with regard to long-term reform of the health system we argue that there are two important messages in relation to future capital investment.

First, the cost of capital (which would allow health services to maintain, repair and replace existing equipment and infrastructure) should be included in the 'price' or funding payments made by all payers of health services (such as payments for public hospitals).

Second, some of our reform proposals will require the investment of new capital, at least on a transitional funding basis. Historically, most capital spending has been directed towards acute hospitals, with relatively low capital investment in other health services. We propose the following priority areas for new capital investment:

- the establishment of Comprehensive Primary Health Care Centres;
- an expansion of sub-acute services;
- an expansion of clinical education; and
- targeted investments in public hospitals to support reshaping of roles and functions, clinical process redesign and a reorientation towards community-based care.

Finally, other than blunt expression through political processes, Australia does not have systematic ways for tapping the views of consumers about the level and purpose of health spending. In line with our principle of public voice and community engagement, we believe there needs to be stronger mechanisms to facilitate broad, informed public debate about the value of health, and how much and what we should spend on health care. We propose a systematic mechanism to formulating health care priorities that incorporates clinical, economic and community perspectives through vehicles such as citizen juries.

Working for us: a sustainable health workforce for the future

A nation's health workforce – its skills, expertise and distribution – is the single most important determinant of quality performance. Australia is exceptionally fortunate in having a highly qualified, dynamic, diverse and dedicated health workforce.

Paradoxically, at the same time as our workforce is acknowledged as a key strength of our health system, it is also seen by many as our key vulnerability.

We face major challenges, including:

- current shortages of professionals in many health occupations, which will be exacerbated with the ageing of the health workforce;
- poor distribution of health professionals across the country, with the numbers of general and specialist medical practitioners, dentists and physiotherapists declining rapidly with distance from major cities;
- with the ageing of the population, an increase in the prevalence of complex and chronic conditions, requiring an increase in health services and changes in the skill mix; and
- professional boundaries, which restrict the ability to use fully the skills of the health workforce.

Our Interim Report puts forward a number of proposals to tackle these challenges. Here we focus on proposals to improve the productivity of our health workforce – often also improving equity of access – and workforce planning and training.

Under our health care system, in theory Australians have universal access to the MBS and the PBS. This is not the case, however, in many rural and remote regions because access to the MBS and PBS generally requires access to a general practitioner.

In response to this situation, we propose facilitating access to care where doctors are scarce in ways which both address inequity of access and improve the productive use of our health workforce. Our proposals take advantage of the fact that nurses are relatively well distributed across Australia.

Commencing in remote and some rural areas we propose that:

- 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.
- PBS subsidies 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 MBS should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialed for defined scopes of practice.

Our next proposal also aims to make more efficient use of the health workforce through a new education framework to facilitate the development of high functioning, multidisciplinary teams. There are several inter-related components to this framework:

- a competency-based framework;
- a flexible, multidisciplinary approach to the education and training of all health professionals;
- a dedicated funding stream for clinical placements for undergraduate and postgraduate students; and
- the provision of clinical training infrastructure across all settings (public and private hospitals, primary health care and other community settings).

Particularly important is the introduction of a competency-based framework. Competencies are what a person needs to do and to know to carry out a particular job role or function. A competency framework would allow for a variety of entry points into health care careers, recognise prior learning, and foster more flexible, multidisciplinary training across undergraduate programs.

Finally, to improve workforce planning and training for a flexible workforce we propose the establishment of a National Clinical Education and Training Agency. The Agency would:

- advise on the adequacy within each major region of the projected provision of health professional education to meet health needs;
- purchase clinical education placements from health service providers, in partnership with universities, vocational education and training, and colleges;
- promote innovation in education and training of the health workforce;
- facilitate the provision of modular competency-based programs to up-skill health professionals in regional, rural and remote Australia to perform tasks and address health needs met by other health professionals in major metropolitan areas; and
- 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.

Fostering continuous learning in our health care system

Research and a culture of continuous learning are important drivers of quality performance, both for a health system and for individual health services and professionals. They underpin innovation, improvement and safety and quality. They support the development of new therapies and cures, and the delivery of more effective health care based on evidence of what works.

It is often said that Australia 'punches above our weight' in health and medical research. But our research efforts should not just be well regarded but also well supported and integrated with clinical practice. This section looks at ways to do this.

We begin with ways to increase research and research infrastructure. We propose that:

- The number of clinical research fellowships should be increased in all health professional groups to establish a new cohort of committed researchers.
- The Commonwealth Government should increase the priority of health services research to facilitate the uptake of research findings into practice.
- Funding for the indirect costs of research (such as library access and information technology) should follow direct grants in all research settings.

The Interim Report also discusses strategies to help bridge the gap between research and clinical practice – the biggest failure in heath care is to implement what we already know. We are encouraged by the NHMRC's plan to stimulate collaborative research efforts by funding 50 virtual research centres that function as a highway between research and clinical practice.

We support building on the NHMRC Centres for Clinical Research Excellence across Australia in a 'hub and spoke' model integrating hospitals and primary health care. These centres should be directed to focus on clinical and health services research programs that look to translate new research findings into interventions that improve the care of patients, or improve access to, or the safety or efficiency of, health services. We propose that the NHMRC consult widely to set priorities for the research centres, including designated resources to regularly disseminate research outcomes to health services.

Safety and quality are some of our key governance principles. Improvements in safety and quality have significant impacts not only on the care and recovery of patients, but also on the productivity and efficiency of the health system. Adverse events and mistakes conservatively cost the health system an estimated $2 billion a year.

In our Interim Report we put forward a number of proposals to reinforce the principles of safety and quality through research, continuous learning and improvement, and strengthened accountability for actions and outcomes.

First, we look to strengthen national leadership in the area. We propose that the Commonwealth Government should broaden the remit of the National Institute of Clinical Studies to include a 'clearinghouse' function to collate and disseminate innovation in the delivery of safe and high-quality health care.

Second, we support educating and training the health workforce in all aspects of safety and continuous quality improvement techniques. 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.

Third, we propose a series of initiatives to respond to the need to systematise access to the evidence base and capture of variation, and to establish data collection, reporting and monitoring systems.

Most importantly, we propose a permanent, independent national body should be established to lead the way on safety and quality (building on the work of the current Australian Commission on Safety and Quality in Health Care which has time-limited funding). A major focus of its role should be to identify and define, by the end of 2009, a set of national indicators that can be used to monitor the safety and quality of care. Using data to compare results among peers of patient outcomes and care processes is one of the most effective levers in supporting positive changes in practice and improving outcomes. Local systems should provide supportive feedback to clinicians, teams and organisations in primary health services and private and public hospitals to build and enable a continuous improvement culture.

Finally, in the spirit of closing the feedback loop, we propose that all health services, whether public or private, should be required to report publicly on their research and quality improvement activities, including reporting on actions arising from investigation of adverse events. The reporting would be linked to ongoing accreditation and the longer-term use of payments for quality.

Next steps

The reform directions we have outlined in our report are presented for comment and discussion, for feedback and review. In developing our proposals, we have focused on long term and systemic solutions rather than short-term fixes. Our proposals are in some senses bold. Although they build on the current strengths of the health system, they destabilise other aspects of the system. They are designed to position us better to meet the real challenges we face.

Our proposals recognise that the locus of change lies with all of us – they promote an Australian way of life that supports healthy lifestyles and behaviour, and endows children with a healthy start to life. Part of this support is our proposal for a comprehensive integrated health care system built on collaboration among health professionals and strengthened primary health care, prevention and health promotion. Our proposals also establish a health care 'learning system', with new structures, governance responsibilities, accountabilities and financial incentives that will create new dynamics for responsiveness, productivity, and quality performance. We also clearly identify some of the issues we, as a nation, need to tackle over the next decade. We are especially determined that Australia must face up to inequities in health outcomes and gaps in health care provision.

Some of our proposals are less advanced than others. Our work in the key areas of e-health and workforce, for example, needs further development for our final report. In other reform areas we have presented options, seeking discussion of possible approaches.

Importantly, as the preferred governance option relating to Commonwealth and state responsibilities is open for discussion, we have not identified in many instances the governance entity responsible for action. Further, since we have not finalised our reform proposals, the financial implications have not been assessed. These tasks will be completed as part of the formulation of a road map for change in the lead up to finishing our final report.

What is clear is that our reform proposals require action from all of us. Those of us who work in the sector will need to make changes in how we work. Governments will need to change how they work and what they are responsible for. Employers, the private sector and providers will all be affected by our proposed changes. We also recognise the importance of individual and community action to build good health.

Given these broad implications, we are keen to get responses and comments from a wide range of people and interest groups. We will submit our final report in June 2009. We look forward to feedback (to talkhealth@nhhrc.org.au) on the proposals in this Interim Report to guide us in that endeavour.

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 is 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.

Introduction

As introduction and background we begin our report with an outline of why the National Health and Hospitals Reform Commission (the Commission) was established, and how we have approached our work. We touch on the highlights of our first report, *Beyond the Blame Game* (April 2008), and in particular recount our design and governance principles, revised following feedback from the community. We also outline the purpose and scope of this report, and provide a guide to the reader about how this report is structured. Finally, we note the next steps toward providing our final report in June 2009.

The National Health and Hospitals Reform Commission

In a Joint Statement issued on 25 February 2008, the Prime Minister and the Health Minister announced the establishment of the National Health and Hospitals Reform Commission to develop a long-term health reform plan for a modern Australia. The Commission's Terms of Reference are at **Appendix A**.

The ten-member Commission **(Appendix B)** was tasked to deliver better health outcomes for the community and provide sustainable improvements in the performance of the health system. The Joint Statement explained that:

> *The National Health and Hospitals Reform Commission will provide a blueprint for tackling future challenges in the Australian health system including: the rapidly increasing burden of chronic disease; the ageing of the population; rising health costs; and inefficiencies exacerbated by cost shifting and the blame game.*
>
> *The Commission will focus on health financing, maximising a productive relationship between public and private sectors, and improving rural health.*

From the outset, we recognised the importance of drawing on the ideas, experiences and views of the Australian community and the health industry to inform our work.

The impressive response to our call for submissions provided a rich array of perspectives and opinions, ideas and suggestions. More than 530 submissions were received from organisations and individuals outlining their views on health reform. A list of these submissions is at **Appendix C**. We acknowledge with great appreciation the interest and goodwill we have received from so many, whether sharing their personal or professional experiences or observations, from across Australia and indeed from around the world.

An invaluable step in connecting with the views of the community and health sector was our 'national listening tour'. We visited every capital city and five regional locations to conduct forums with members of the community, frontline health workers, government agencies, industry groups and opinion leaders. A list of community engagement forums is at **Appendix D**. Reports of these forums can be viewed on the NHHRC website at www.nhhrc.org.au

The Commission also conducted workshops, special interest meetings and face-to-face meetings, and attended invited presentations with over a hundred organisations, associations and interest groups.

We commissioned a range of expert discussion papers in key areas such as primary health care, prevention, governance, the mix of public-private financing and service provision, oral health and health expenditure projections. These discussion papers are listed at **Appendix E** and can be viewed on the NHHRC website at www.nhhrc.org.au

We also researched and analysed international literature and met with leading health experts in Australia and from around the world.

In an environment of considerable health reform activity, we have been mindful of the work of other groups including the Australian Commission for Safety and Quality in Health Care, the Closing the Gap Steering Committee for Indigenous Health Equality, the National Health Workforce Taskforce, the National Preventative Health Taskforce, the National Primary Health Care Strategy External Reference Group, the Review of Maternity Services being undertaken by the Commonwealth Chief Nurse and Midwifery Officer, and the review of rural health programs by the Office of Rural Health in the Commonwealth Department of Health and Ageing. Given our brief, we have focused on the long term and big picture reform agenda for the health system as a whole, while working collaboratively with these groups.

We commend the recent discussion document of the National Preventative Health Taskforce, *Australia: the Healthiest Country by 2020* (September 2008), which our report reinforces and complements with suggested governance and financing propositions. Similarly, we note and support the discussion paper from the Australian Government, *Toward a National Primary Health Care Strategy* (October 2008). We acknowledge with appreciation the support of the Australian Commission on Safety and Quality in Health Care, particularly their assistance with information and discussion which stimulated our thinking on the critical role of the safety and quality agenda in health and health reform.

The Commission has also noted the recent health policy announcements and recommendations of the Council of Australian Governments (COAG), the Australian Health Ministers' Conference (AHMC), the Garling Report (NSW), and other forums. The November 2008 COAG decisions came late in our deliberations and so we have not incorporated these in this Interim Report.

Our first report – Beyond the Blame Game (April 2008)

Our first report, *Beyond the Blame Game* (April 2008), provided early advice to inform the negotiations of the Australian Health Care Agreements of likely reform directions and to provide relevant performance indicators and benchmarks reflecting our long-term view of the health system.

Beyond the Blame Game is available on the NHHRC website at www.nhhrc.org.au

In preparing that report, we took the approach that the next generation of Australian Health Care Agreements should go beyond hospitals and that accountability should be clear and two-way. We noted that all governments had acknowledged that there must be greater accountability in health service delivery.

A set of design and governance principles was developed by the Commission to underpin the health system of the future. We released them for comment and feedback, and the final principles have been revised to reflect the feedback and good ideas we received and are presented in **Appendix F**.

The purpose and scope of this report

This Interim Report continues our reform journey. It contains our thinking on the challenges facing the health system now and in the future, highlights strengths we can build on and indicative directions for long-term reform following extensive consultation and discussion.

One of the biggest challenges in our work has been to take a truly long-term view and not to get consumed by issues and solutions that are only about the here and now. It is easy to see a problem and tailor a single solution to fix it – a point solution – rather than thinking about how patterns of problems could be resolved by system solutions, which is our task.

This report examines ways to create a healthier future for all Australians through four themes:

- **Taking responsibility:** individual and collective action to build good health and wellbeing – by people, families, communities, health professionals, employers and governments (Chapter 1).
- **Connecting care**: comprehensive care for people over their lifetime (Chapters 2 to 7).
- **Facing inequities**: recognise and tackle the causes and impacts of health inequities (Chapters 8 to 11).
- **Driving quality performance**: better use of people, resources, and evolving knowledge (Chapters 12 to 15).

While the themes provide an organising framework for clustering and presenting our health care reforms, the themes also apply across the various chapters.

Chapter 1 examines strategies to build healthier communities and healthier people. It is a call to action for all of us – people, families, communities, health professionals, employers and governments – individually and collectively to take responsibility for our health, the health of our children, and the health of Australia.

In Chapters 2 to 7, we focus on people getting the right care, in the right place, at the right time – over time. We emphasise strengthening primary health care as the foundation of the health system, providing continuity and coordination of care for people with chronic and complex conditions; the value of investing in a healthy start to life; strategies to improve timely access and safe care in hospitals; completing the care continuum by filling the 'missing link' of sub-acute services; creating greater choice for older people; and respecting the rights and choices of people at the end of life.

Chapters 8 to 11 highlight the urgent need to face up to and tackle inequities in health status, health outcomes and access to health services for many groups in our community. Specifically, we discuss strategies to tackle inequities affecting Aboriginal and Torres Strait Islander peoples, rural and remote communities, people with mental health conditions, and people with poor access to dental services.

Finally, Chapters 12 to 15 consider issues related to governance, funding, the health workforce, quality and research. Our reform directions aim to improve leadership, drive productivity and efficiency, deliver better outcomes, engage and support our people working in health, and foster an environment of continuous learning to harness innovation now and into the future.

The next steps

This is an Interim Report and remains a work in progress. We recognise that we are further advanced in some areas of focus than others. Our work in the key areas of e-health and workforce, for example, will be further developed in our final report. We are also yet to fully explore the opportunities and challenges that new technologies may present, and their influence on health care and our world in the future. In some instances, we have presented options and our work to date will benefit from further discussion.

Importantly, as the preferred governance option relating to Commonwealth and state responsibilities is open for discussion, we have not identified in many instances the governance entity responsible for action. Further, since we have not finalised our reforms, the financial implications have not been assessed. These tasks will be completed as part of the formulation of a road map for change in the lead up to finishing our final report.

One of the key purposes of this Interim Report is to provide an opportunity for the Commission to canvass some important options and ideas to stimulate discussion and gauge support and views from the community and health sector as we finalise our deliberations.

We encourage feedback through talkhealth@nhhrc.org.au. Importantly, we seek early responses as we will be moving to complete and finalise our reform agenda and commence the work of implementation planning and developing a road map for change for our final report, which is due at the end of June 2009.

TAKING RESPONSIBILITY

INDIVIDUAL AND COLLECTIVE ACTION TO BUILD GOOD HEALTH AND WELLBEING – BY PEOPLE, FAMILIES, COMMUNITIES, HEALTH PROFESSIONALS, EMPLOYERS AND GOVERNMENTS

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

Key messages

- Health is everybody's business. Good health has intrinsic value. A healthy population also helps support a healthy economy. Action to protect and promote health may also support our efforts to save the health of our planet.
- Despite universal entitlement to health services, there are still some groups in our population who have unacceptably poor health status and reduced access to health services. These health inequities are experienced particularly by Aboriginal and Torres Strait Islander peoples, but other groups also face significant disadvantage.
- Prevention can and should occur across the whole health system. Every 'curative' visit or intervention should also have a prevention component. Similarly, prevention and health promotion applies to people of all ages, no matter what their health status is.
- Many factors contribute to building healthier communities. Over and above our use of health services and our personal health behaviours, social and economic factors, including the built environment, play a strong role in influencing the health of our population. Access to employment, education, housing, early childhood development, clean air, and safe food and water contribute to our health.
- There is opportunity to translate the talk about prevention into clear action that enables individuals, communities, workplaces, schools, private health insurers, health services and governments to all play a part in boosting the role of health promotion and prevention. While prevention should be everybody's business, there is a vacuum in national leadership on health promotion and prevention.
- There is a lack of evidence about 'what works' in prevention and health promotion. Unlike many other parts of the health system, we do not have a systematic process to assess the evidence on preventive interventions and there is no readily identifiable funding mechanism for prevention and health promotion.
- For many people, healthy choices are not currently easy choices. Many Australians have very low levels of health and general literacy, and are not well equipped to take personal responsibility for improving their own health.

Our reform directions

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 health of 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 is 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

A healthy population is everybody's business.

We care about health as a community because:

> *The way we live is making people sick. It is also making our planet sick. It is not sustainable. We can do better.*[1]

We care about health as a community because:

> *Health is unequally distributed across socio-economic groups; those with poorer indices of socio-economic participation have poorer health.*[2]

We care about health as a community because:

> *Health is major sector in the economy and a significant employer and generator of economic activity yet the discussion around health is always about it being a burden on the economy. A healthy population underpins our economy.*[3]

We care about health as a community because:

> *There are no magic tablets in the laboratory. It will require all of us as individuals and families to make healthier choices.*[4]

We begin our report by considering the role of health in our lives and the strategies we need to build healthier communities and healthier people. We apply two lenses to the way in which we examine these issues.

First, we take a population health perspective in identifying issues that are relevant to building healthier communities. In Sections 1.1 to 1.6, we:

- examine the links between health and our national wealth;
- present evidence on the challenge we face concerning health inequities whereby some groups in our community have much worse health outcomes or poorer access to services than the general community;
- consider the social determinants that influence the health of our communities and inequities in health outcomes;
- propose how better health can be promoted in all settings – including our local communities and workplaces – over and above our contact with health professionals and health services; and
- identify strategies to create both national leadership and local action on prevention and health promotion.

Second, we take a consumer empowerment perspective in considering how individuals can take greater responsibility for their own health. In Section 1.7, we report the views from our submissions and consultations about what health means and how to stay healthy. In Section 1.8, we discuss how to strengthen health literacy, one essential element that consumers need if they are to make informed decisions and choices about their health and use of health services.

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[1] The Oxford Health Alliance (2008) The Sydney Resolution: Healthy people in healthy places on a healthy planet, at: http://www.oxha.org/meetings/08-summit/sydney-resolution

[2] VicHealth (2008), Submission 187 to the National Health and Hospitals Reform Commission.

[3] Government official (24 June 2008), National Health and Hospitals Reform Commission consultation meeting with government agencies in Melbourne.

[4] National Preventive Health Taskforce (2008), Australia: the healthiest country by 2020, Discussion paper, at: http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/discussion-technical-1

While this chapter is largely about how we can improve health through strategies outside the health system, we believe that it is also important to stress the integral role of prevention and health promotion within the health care system. Health professionals have the opportunity to treat each visit by a patient as a potential health promotion and prevention intervention. Moreover, consistent with our life course approach to health (outlined further in Chapter 2), we agree with the views of Aged and Community Services Australia who argue that:

> *Many discussions of prevention are not cognisant of the fact that effective preventative services and practices can be valuable at any age. It's not too late for older people to benefit from exercise programs, a good diet or ceasing substance abuse.*[5]

1.1 Recognising the importance of healthy communities

Health and wealth go hand in glove, both for nations and for individuals

- Health and wealth go hand in glove, both for nations and for individuals.

The World Health Organization (WHO) acknowledges the dual importance of healthy communities: first, as a priority goal in its own right; and, second, as a central input into economic development and poverty reduction.[6] WHO's Commission on Macroeconomics and Health identified that:

> *Countries with higher levels of health grow faster and, indeed, improvements in health may account for a significant fraction of the rapid economic growth of much of the world in the 20th century.*[7]

Similarly, in Australia, the Council of Australian Governments' National Reform Agenda was grounded on the then radical view that the path to greater economic prosperity lay with a new 'human capital' agenda. The 'three Ps' agenda linked prosperity to greater productivity and higher labour force participation (see Figure 1.1).

> *Improving health, learning and work outcomes is the path to building a healthy, skilled and motivated society, and an economy that is among the world's best … The ability of our health system to improve public health, and to prevent and manage ill-health, directly shape the economy's productive capacity. A strong economy can only ever be built on a healthy active society … Improving health and limiting the incidence and impact of ill-health would enable both more people to work, and those who do so to work more productively.*[8]

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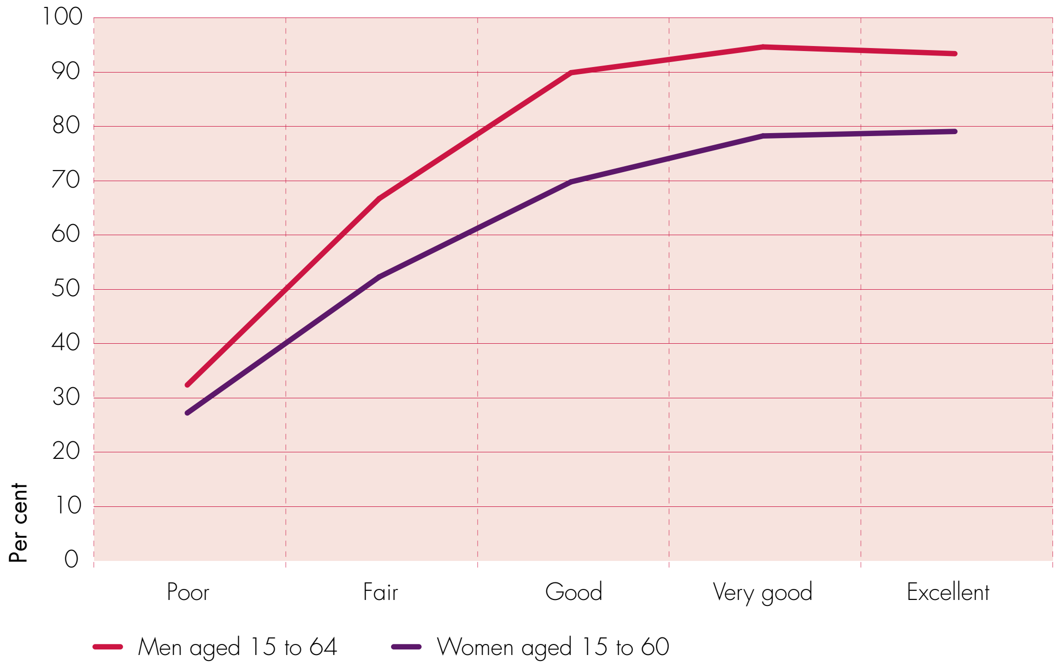
[5] Aged and Community Services Australia (2008), Submission 6 to the National Health and Hospitals Reform Commission.

[6] World Health Organization (2001), Macroeconomics and health: Investing in health for economic development, Final report: Executive summary, at: http://whqlibdoc.who.int/hq/2001/a74868.pdf

[7] World Health Organization (2000), Commission on macroeconomics and health: background, at: http://www.globalhealth.ie/information-archives/article/19

[8] Victorian Department of Premier and Cabinet (2005), Governments working together: A third wave of national reform, at: http://www.dpc.vic.gov.au/CA256D800027B102/Lookup/A_Third_Wave_of_National_Reform/$file/A%20Third%20Wave%20of%20National%20Reform.pdf

Figure 1.1: Participation in the workforce increases as health status improves



Source: Victorian Department of Premier and Cabinet (2005), Governments working together: A third wave of national reform.

In recent years, there has also been an increasing interest in linking the health of our communities with the health of our planet. In February 2008, the Oxford Health Alliance issued an international call to action through its Sydney Resolution, titled *Healthy People in Healthy Places on a Healthy Planet.*[9] The alliance argued that urgent action was needed, bringing together dedicated stakeholders from all parts of society, to tackle the epidemic of preventable chronic diseases.

There is now widespread recognition of the importance of global warming, and the importance of changing what we do now to save the health of our planet. Many of the things we need to do to address global warming, such as reducing carbon emissions from cars by making it easy to go to work or school by bicycle, are the same things we need to do to reduce the risk of future chronic disease.

1.2 Facing inequities in health

Following a three-year multi-national study, the WHO Commission on the Social Determinants of Health recently found that:

> *Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years. And within countries, the differences in life chances are dramatic and are seen worldwide. The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off.*

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[9] The Oxford Health Alliance (2008), The Sydney Resolution: Healthy people in healthy places on a healthy planet, at: http://www.oxha.org/meetings/08-summit/sydney-resolution

> *In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.*[10].

Many of us may believe that these findings mainly apply to 'Third World' countries, but not to Australia. We like to think of ourselves as a 'classless', egalitarian society where everyone has equal opportunity. We may also believe that, with our mix of Medicare and private health insurance, there are few barriers or inequities in regard to gaining access to necessary health care and that health is evenly distributed across our population.

The appalling health status of our Aboriginal and Torres Strait Islander peoples provides the most clear-cut repudiation of that position.[11].

- Aboriginal and Torres Strait Islander men have a life expectancy of 59 years, compared with 77 years for all men; life expectancy is 65 years for Aboriginal and Torres Strait Islander women compared with 82 years for all women.
- In 2005–06 Aboriginal and Torres Strait Islander peoples were hospitalised at 14 times the rate of other Australians for care involving dialysis.
- Aboriginal and Torres Strait Islander peoples were hospitalised for potentially preventable conditions at five times the rate of other Australians.
- In 2004–05 Aboriginal and Torres Strait Islander adults were twice as likely as other Australians to report their health as only fair or poor.

The extent of disadvantage and poor health outcomes among our Aboriginal and Torres Strait Islander peoples is well known. In Chapter 8 of this report, we return to this issue in proposing strategies to 'close the gap' for Aboriginal and Torres Strait Islander peoples.

However, we sometimes fail to recognise that there are also major disparities in health outcomes and access to health services for other population groups in our community. This concern was clearly expressed through some of our submissions, including:

> *In being inclusive, responsive and equitable, it is important that our health system acknowledges the specific issues that face different population groups, and does not treat all Australians as fitting within a homogenous group. Invisibility within the health system does not equate to equity being achieved.*[12]

People with a long-term disability are among the most disadvantaged, and invisible, groups in our community

People with a long-term disability are among the most disadvantaged, and invisible, groups in our community, with very poor health status and a health system that often fails to meet their special needs. This includes people with an intellectual disability (see Figure 1.2), as well as people with other long-term physical and mental conditions, whether present at birth or acquired later in life.

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[10] Commission on social determinants of health (2008), Closing the gap in a generation: Final report executive summary, at: http://www.who.int/social_determinants/en/

[11] Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2008, at: http://www.aihw.gov.au/publications/ihw/hwaatsip08/hwaatsip08.pdf

[12] National GLBT Health Alliance (2008), Submission 124 to the National Health and Hospitals Reform Commission.

Figure 1.2: There are stark health and access inequalities for people with an intellectual disability

There are currently over 300,000 Australians with intellectual disabilities, many of whom have health outcomes at least as bad as our Aboriginal and Torres Strait Islander peoples. Published research on the health outcomes for people with an intellectual disability identifies that:

- Life expectancy may be up to 20 years lower for people with a severe intellectual disability than the general population.
- There is a huge burden of undiagnosed illness. Only 29 per cent of health conditions are diagnosed and treated appropriately in this population. Some 42 per cent of health conditions go undiagnosed. And, even when health conditions are diagnosed, half of those patients still have their conditions inadequately managed.
- Psychiatric disorders are among the conditions that are frequently not well diagnosed or managed in people with an intellectual disability.
- Dental disease is up to seven times more common than in the general population.

Some of the many factors that contribute to poorer health outcomes for people with an intellectual disability include:

- 'Diagnostic overlay' – health professionals may assume that the symptoms are part of the intellectual disability, not a separate health condition that requires treatment.
- Communication challenges – there will often be a need to spend much more time with people with an intellectual disability and many health professionals may not have sufficient training in how best to communicate with such patients.
- Workforce challenges – few health professionals will have specialised training or exposure to people with intellectual disabilities, recognising that there is a wide array of disabilities, often accompanied by other health problems.
- There is a lack of targeting of people with intellectual disabilities in health promotion and prevention strategies.
- Other challenges include the high cost of providing comprehensive and holistic care for some people with an intellectual disability, the lack of support for families and carers, and the lack of societal value attached to people with intellectual disabilities.

Source: Australian Association of Developmental Disability Medicine Incorporated and the National and NSW Councils for Intellectual Disability (2008), Submission 450 to the National Health and Hospitals Reform Commission.

People from other countries, and people with other languages and other cultures, may also be at a significant disadvantage in our health system. We heard through our submissions of the challenges faced by health professionals to respond appropriately to 'an increasing diversity of culture with diverse languages, cultural practices and ethical frameworks'.[13] While migrants, who are screened for health status prior to migration, are generally healthier[14] – with lower rates of hospital use, fewer health risk factors and lower death rates – they may face an uphill battle in getting access to services that meet their needs. Although not all refugees have access to Medicare[15], refugees generally have lower rates of hospital admissions, including preventable admissions, than Australian-born people.[16] At the most basic level, however, communication for many migrants can remain a major challenge, with one of our submissions suggesting that there was a need for a review of national interpreter and translation service standards and credentialing of these services.[17]

■ People from other countries, and people with other languages and other cultures, may also be at a significant disadvantage in our health system

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13 B Hayes (2008), Submission 235 to the National Health and Hospitals Reform Commission.

14 Australian Institute of Health and Welfare (2002), Australian health inequalities: 1. Birthplace, AIHW Bulletin No. 2, at: http://www.aihw.gov.au/publications/index.cfm/title/7722

15 I Correa-Velez, S Gifford and S Bice (2005), 'Australian health policy on access to medical care for refugees and asylum seekers', Australia and New Zealand Health Policy (2):23, at: http://www.anzhealthpolicy.com/content/pdf/1743-8462-2-23.pdf

16 I Correa-Velez, Z Ansari, V Sundararajan and colleagues (2007), 'A six-year descriptive analysis of hospitalizations for ambulatory care sensitive conditions among people born in refugee-source countries', Population Health Metrics, at: http://www.pophealthmetrics.com/content/pdf/1478-7954-5-9.pdf

17 Doutta Galla Community Health Service (2008), Submission 79 to the National Health and Hospitals Reform Commission.

We have identified 'facing inequities' as one of our four major pathways to reform. In talking about equity, we want to be clear that equity does not necessarily mean 'equal' access or 'equal' outcomes for all people. When we consider, for example, the 17-year life expectancy gap between Aboriginal and Torres Strait Islander peoples and other Australians, it should be obvious that providing 'equal' access to services or 'equal' levels of funding will simply not be enough. In this situation, the concept of 'vertical equity' comes into play: meaning we need 'unequal but equitable access for unequal need'.[18] As we discuss in Chapter 8, the level of resources needs to be proportionate to the greater health problems and disadvantage faced by this population.

We believe that there is an urgent need to tackle inequities in access to health services, health status and health outcomes. In Chapters 8 to 11 of this report, we propose reform directions to tackle inequities affecting Aboriginal and Torres Strait Islander peoples, rural and remote communities, people with mental health conditions, and people with poor access to dental services.

We cannot simply assume that universal entitlement to health care services equates to a health care system that fosters equitable health outcomes for all groups in our community

Also, because some, but not all, of the causes of inequity in health outcomes relate to the affordability of services, we examine in Chapter 13 the costs of health services for different households, and outline further work on the development of integrated safety nets. We cannot simply assume that universal entitlement to health care services equates to a health care system that fosters equitable health outcomes for all groups in our community.

Reform direction 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.

The WHO Commission on Social Determinants of Health has expressed this concept as follows:

> *Most governments tend to have a mixture of both universal and targeted social policies. However, in the more successful countries, overall social policy itself has been universalistic, and targeting has been used as simply one instrument for making universalism effective; this is what … [is] referred as 'targeting within universalism', in which extra benefits are directed to low-income groups within the context of a universal policy design and involves the fine-tuning of what are fundamentally universalist policies.*[19]

In other words, we need to move beyond the 'she'll be right' passive version of universal entitlement to a new paradigm that recognises our responsibility to target groups whose health outcomes, and access to health services, may be worse than average. Many strategies could contribute to this renewed paradigm of universalism and we welcome feedback on this approach. For example, some submissions identified the need for targeting and outreach strategies for some populations:

> *Every publicly funded health education and screening program should be required to include those citizens who cannot present themselves.*[20]

> *If the Commonwealth Government is committed to achieving equity, it is essential that they commit further health resources according to need, rather than simply applying a one-size-fits-all approach to healthcare.*[21]

Another important approach which we identified in our first report, *Beyond the Blame Game*, is to report, separately and publicly, on benchmarks for the health of particular populations. We

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[18] G Mooney (2008), Submission 275 to the National Health and Hospitals Reform Commission.

[19] World Health Organization Commission on Social Determinants of Health (2007), A conceptual framework for action on the social determinants of health: Discussion paper, at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

[20] Australian Association of Developmental Disability Medicine Incorporated and the National and NSW Councils for Intellectual Disability (2008), Submission 450 to the National Health and Hospitals Reform Commission.

[21] ACT Council of Social Services & Women's Centre for Health Matters, Submission 4 to the National Health and Hospitals Reform Commission.

suggested in our first report that this could include separate reporting on Indigenous versus non-Indigenous populations, rural versus metropolitan, and lower socio-economic status versus higher socio-economic status groups in our population. Since 1998, the Australian Institute of Health and Welfare has set a positive example in its biennial *Australia's Health* report, analysing and reporting on patterns of health across different sub-populations. It argues that this is important, first, for the 'basic social issue of fairness' and, second, because understanding different patterns of health is necessary to identify opportunities to improve the health system and wider social improvements.[22]

Reform direction 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 Tackling the social determinants of health

Many of the factors contributing to health inequities sit well and truly outside our health system. In the words of a GP attending one of our consultation meetings:

> *Health … cannot be separated from social issues, issues of wealth, issues of infrastructure at all levels in Australia, be that in a metropolitan, outer-metropolitan, regional, remote [setting] etc. and so on. You will not solve a lot of the health problems in this country if you look at health in isolation. You have to look at socio-economic groups, you've got to look at social welfare, you have to look at self-empowerment and education which begins in schools.*[23]

Similarly, the Public Health Association of Australia has argued that:

> *There is now a significant body of evidence about the direct impacts of the social determinants of health on individuals, communities and populations. Social determinants of health are the strongest predictors of people's health, structuring our opportunities in life and lifestyle choices. Taking account of social conditions that underlie health and how they translate into health impacts is critical for overcoming the deep divide between 'haves' and 'have-nots' and the social unrest that arises from such disparities.*[24]

A comprehensive framework that explains the links between health and the 'social determinants' of health was recently developed by the WHO Commission on Social Determinants of Health (see Figure 1.3). This framework identifies that many of the factors influencing our ability to be healthy are outside the direct control of individuals. Government policies relating to income protection and social support influence how we are able to raise our children and what opportunities we can provide them. At a more direct level, our educational standards will affect our abilities to find and understand health-related information.

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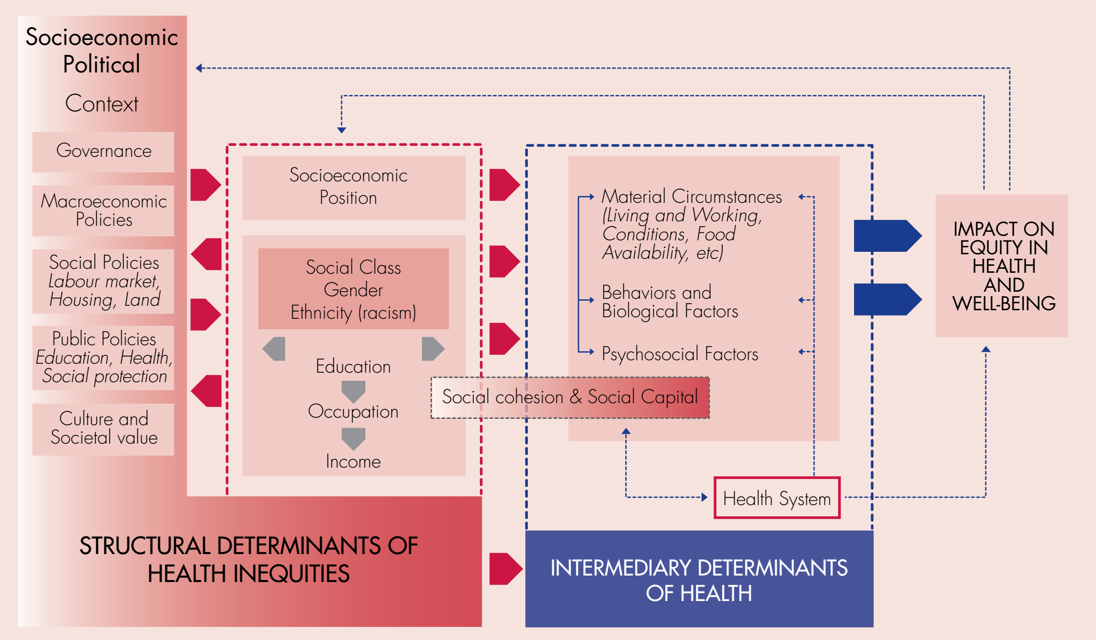
[22] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

[23] General practitioner (7 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Perth.

[24] Public Health Association of Australia (2008), Submission 429 to the National Health and Hospitals Reform Commission.

Figure 1.3: There are many 'social determinants' that influence the health and wellbeing of our communities



Source: World Health Organization Commission on Social Determinants of Health (2007), A conceptual framework for action on the social determinants of health: Discussion paper, at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

The Commission on Social Determinants of Health used this framework to identify that there were three broad, complementary strategies that could be used to reduce health inequities[25], namely:

- introducing targeted programs for disadvantaged populations;
- closing health gaps between worse-off and better-off groups; and
- addressing the social health gradient across the whole population.

From our perspective, we have debated long and hard about the approach we should take to proposing reform directions that involve groups and government agencies outside the health care system.

Cross-sectoral action is an essential ingredient to tackling the problem of health inequity

Clearly, cross-sectoral action is an essential ingredient to tackling the problem of health inequity. We have been pleased to see the establishment by the Commonwealth Government of the Australian Social Inclusion Board. This Board has been challenged with achieving better outcomes for the most disadvantaged in our community.[26] Priorities identified by the Commonwealth Government for early action by the Board include:

- addressing the incidence and needs of jobless families with children;
- delivering effective support to children at greatest risk of long-term disadvantage;
- focusing on particular locations, neighbourhoods and communities to ensure programs and services are getting to the right places;
- addressing the incidence of homelessness;
- providing employment for people living with a disability or mental illness; and
- closing the gap for Aboriginal and Torres Strait Islander peoples.

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[25] World Health Organization Commission on Social Determinants of Health (2007), A conceptual framework for action on the social determinants of health: Discussion paper, at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

[26] Information on the Australian Social Inclusion Board, at: http://www.socialinclusion.gov.au/aus_inclusion_board/

Many of these issues are crucial to tackling health inequities and go to the cause of why Australia, and indeed most countries, has a social health gradient.

Other groups can also have an important role in stimulating cross-sectoral action. Our proposal for the establishment of a national prevention and health promotion agency (see Section 1.6) is based strongly on the need for such an agency to engage collaboratively with many groups who sit 'outside' the current health system.

We further note the galvanising effect in some countries of major reports on the relationship between social policies and health equity. The ground-breaking Black Report on inequalities in health was the catalyst for major change, not only in the United Kingdom, but it spurred national inquiries and action in many other countries including the Netherlands, Spain and Sweden.[27] Similarly, in the United States, the Agency for Healthcare Research and Quality produces an annual National Healthcare Disparities Report[28] that measures quality and access among various racial, ethnic and income groups, as well as other priority populations such as children, older adults, rural residents and people with disabilities. The publication of such reports helps 'keep us honest' about whether we are doing enough to tackle some of the systemic issues that lead to health inequities.

A precursor for action on health inequity is that the issue becomes visible.

Reform direction 1.3

We propose the preparation of a regular report that tracks our progress as a nation in tackling health inequity.

1.4 Promoting health in our local communities

A strong feature of the consultation feedback we received was how to combine the best elements of a 'national' health system with 'local' engagement and innovation.

We believe it is important to match national action on social determinants and health inequity with local participation and action to tackle problems that influence the health of our local communities. There is a wealth of ideas and a passionate enthusiasm among many local communities about how they can make their communities healthier places to live.

- There is a wealth of ideas and a passionate enthusiasm among many local communities about how they can make their communities healthier places to live

Across the country, many local councils develop population health plans, working collaboratively with local community health services and their communities. Many other groups are also strongly engaged in creating healthier local communities (see Figure 1.4).

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27 World Health Organization Commission on Social Determinants of Health (2007), A conceptual framework for action on the social determinants of health: Discussion paper, at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

28 Agency for Healthcare Research and Quality (2008), National healthcare disparities report 2007, at: http://www.ahrq.gov/qual/qrdr07.htm

Figure 1.4: Local communities are 'doing' health promotion 'for themselves'

We read and heard of many examples of local action to promote healthy communities. Some of these stories follow.

Sustainable farm families

> *In western Victoria, the Sustainable Farm Families project was started by the Western District Health Service in 2003. With the motto 'No point in a better bottom line if you're not there to enjoy it', the project takes an early intervention approach to working with families who may be facing tough financial circumstances. Over 1000 farmers and 100 rural health professionals are involved in a 'settings based' approach to health promotion. This project recognises that the health of farming families and communities is a resource that needs to be proactively nourished and supported, moving beyond the simple provision of curative health services.*

Afghani women's swim team

> *In Hobart, the Migrant Resource Centre has organised an Afghani Muslim women's swim team. The women gather regularly for swimming lessons, with a Farsi speaking interpreter in a 'women only' session at a local pool. These sessions promote the importance of exercise, but also help the women bond and form new friends while they are learning to adjust to living in a new country.*

Food security, nutrition, physical activity and social inclusion

> *In inner Melbourne, the Inner South Community Health Service defines health promotion as 'the process of enabling people to increase control over the determinants of their health, thereby improving it'. The health service runs several activities that are linked to promoting social inclusion, food security and nutrition, and encouraging physical activity. These include: community gardens projects to increase access to nutritious food and create opportunities for social connection and physical activity; a fortnightly gathering and lunch for the Aboriginal and Torres Strait Islander community, our Rainbow Place, which is led by community elders; and a community winter breakfast program that aims to bring community members together over a healthy breakfast.*

Sources: Sustaining Farm Families project: Victorian Healthcare Association (2008), Submission 190 to the National Health and Hospitals Reform Commission.

Afghani women's swim team: Community member (29 May 2008), National Health and Hospitals Reform Commission consultation meeting with consumers in Hobart. See also: http://www.mrchobart.org.au/index.shtml

Inner South Community Health Service: Health promotion plan 2006–2009, http://www.ischs.org.au/Whoweare/CommunityHealth/Ourhealthpromotionplan/tabid/113/Default.aspx

Local community engagement in building healthier communities requires information about local health issues and priorities. One approach canvassed at the 2020 Summit in April 2008 was the development of a 'wellness footprint'.[29] This was described as being similar to a 'carbon footprint', but it would measure a range of factors that contribute to healthy communities covering issues such as urban planning and schools.

In fact, we learned during our national consultations that a similar concept, called Community Indicators Victoria, has been operational since July 2007.[30] The Community Indicators Victoria website presents a broad array of information on the health of local communities (available at the level of local government areas) against five major domains:

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[29] Australian Government (2008), Australia 2020 Summit – Final Report, at: http://www.australia2020.gov.au/final_report/index.cfm

[30] Community Indicators Victoria, at: http://www.communityindicators.net.au/

- Healthy, safe and inclusive communities;
- Dynamic, resilient local economies;
- Sustainable built and natural environments;
- Culturally rich and vibrant communities; and
- Democratic and engaged communities.

Everyone is able to look up how their community (or any Victorian community) measures up against about 80 indicators (see Figure 1.5) within these five domains. Maps can be created to show how your community is tracking relative to other Victorian communities on indicators such as: child health assessments, school retention rates, unemployment, household waste recycling, public transport patronage, and household affordability. The Community Indicators Victoria website provides a tool that local communities can use to 'get local conversations started' in building healthy communities.

Figure 1.5: Victorians can access information about the health of their communities

Community wellbeing indicators reported on the Community Indicators Victoria website are grouped against five domains. These domains are further split into several elements which have about 80 indicators listed under the elements. (The actual indicators are not listed here due to space limitations.)

1. Healthy, safe and inclusive communities

  a. Personal health and wellbeing
  b. Community connectedness
  c. Early childhood
  d. Personal and community safety
  e. Lifelong learning
  f. Service availability

2. Dynamic, resilient local economies

  a. Economic activity
  b. Employment
  c. Income and wealth
  d. Skills
  e. Work–life balance

3. Sustainable built and natural environments

  a. Open space
  b. Housing
  c. Transport accessibility
  d. Sustainable energy use
  e. Air quality
  f. Water
  g. Biodiversity
  h. Waste management

4. Culturally rich and vibrant communities

  a. Arts and cultural activities
  b. Leisure and recreation
  c. Cultural diversity

5. Democratic and engaged communities

  a. Citizen engagement

The Community Indicators Victoria website allows reports and websites to be generated for each of the indicators for every local government area in Victoria. Detailed information is available on how the indicators are defined and collected. Case studies are also provided on how local communities are using the community indicators in planning for healthy communities

Source: Community Indicators Victoria, at: http://www.communityindicators.net.au/

Reform direction 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 Promoting health in our workplaces

Communities can take many shapes. In our discussion above, we were mainly focusing on communities united by geography. Each of us participates in many communities – whether they are schools, sporting clubs, church groups or any other of the spheres of our lives. For some of us, our workplace is another such community.

Businesses and employer groups have become increasingly engaged in the public debate about health reform. This makes absolute sense given the close relationship between a healthy workforce and economic productivity. As we heard in one of our submissions:

> *Because health is so fundamental to a nation's social and economic prosperity, the Business Council of Australia supports the view that health is everybody's business, including Australia's businesses. For too long health policy decisions have been seen as a matter for governments and the health sector. But as we face new possibilities and difficult choices about the allocation of scarce resources, we all need to take responsibility for understanding the challenges and participating in the debate.*[31]

At the level of individual businesses, the traditional focus of workplace health on occupational health and safety issues is expanding to include new programs targeting wellness, health promotion, risk screening and self-management for workers with chronic diseases.

Currently there are about 35 corporate wellness providers in Australia who provide services to about 500,000 employees, equal to five per cent of the total workforce.[32] Private health insurers are also increasingly providing similar services to their members, including wellness, risk assessment and support for people with chronic disease. There is some overlap between these programs and populations, although privately insured people include those outside the workforce as well as employed people. However, the general point is that wellness and health improvement programs are being offered outside traditional health service providers. And, of course, many people also participate in other non-sponsored activities to keep them healthy, such as sporting activities or gym memberships.

Investment by businesses and private health insurers in health management and wellness programs reflects a commercial assessment that such programs generate a positive return on investment

Investment by businesses and private health insurers in health management and wellness programs reflects a commercial assessment that such programs generate a positive return on investment. In its submission[33], the Health and Productivity Institute of Australia provided examples of, and evidence on, the cost-effectiveness of such programs to employers, including:

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[31] Business Council of Australia (2008), Submission 319 to the National Health and Hospitals Reform Commission.

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

[33] The Health and Productivity Institute of Australia (2008), Submission 334 to the National Health and Hospitals Reform Commission.

- A recent international review of workplace wellness programs found that the average cost benefit ratio for such programs was about 1:6. Every dollar invested in workplace wellness programs generated a return of six dollars.
- In Australia, a health and wellbeing program offered to ANZ employees improved the rate of work time lost from employee poor health and injury by 23 per cent over two years.
- Members of one Australian private health insurance company had lower claims ($50 annually) against their health insurer if they completed a health risk assessment questionnaire and even lower claims ($500 annually) if they also participated in health coaching that was relevant to their identified risks and health problems.

While businesses are already investing in workplace health programs, we also received advice about strategies to encourage further growth of such programs.[34] These included:

- the introduction of government financial support for such programs;
- amending various tax provisions to promote greater uptake of workplace health programs;
- changing private health insurance rules to promote health screening; and
- encouraging the development of a national wellbeing index with workplace health programs being one of the groups that would collect data on the wellbeing of the working population.

We note that some governments are already investing in workplace health programs. Tasmania has allocated funding of $3.3 million to fund workplace health programs for its public servants[35], while the Victorian Government announced a five year, $600 million investment to fund screening for preventable diseases for 2.6 million workers.[36] We are also aware that there are several wellbeing indices being developed or already in use; for example, since 2001, Australian Unity, in association with Deakin University, has collected and reported information on a personal wellbeing index.[37]

Reform direction 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.

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[34] The Health and Productivity Institute of Australia (2008), Submission 334 to the National Health and Hospitals Reform Commission.

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

[36] Victorian Government (2008), World first plan to help workers fight chronic disease, Media release, 18 March 2008.

[37] Australian Unity (2008), What makes us happy: Australia's first and foremost guide to wellbeing, at: http://acqol.deakin.edu.au/index_wellbeing/Survey_18.2.pdf

1.6 Encouraging national leadership on health promotion and prevention

Our examination of strategies to support health promotion and prevention at the national level has been influenced by a range of material including:

- the outcomes of the National Prevention Summit[38];
- the work of the National Preventative Health Taskforce[39];
- a series of discussion papers that we commissioned on various strategies to expand the role of prevention and health promotion[40]; and
- the views that we received through our submissions and consultation meetings.[41]

There was strong support from many sources for national leadership on health promotion and prevention. For example:

> *We need a new agenda to elevate prevention to a national priority and to fund it appropriately. This national prevention agenda needs to be accompanied by developing good working relationships between a range of existing and new players, including the public, who are the ultimate beneficiaries of investment in health.*[42]
>
> *Social change management strategies will need to be employed to shift the society from an illness model to a wellness model. Stop bragging about having the best health system in the world. It's time to start bragging about Australia having the best wellness system in the world.*[43]

National leadership on health promotion and prevention can occur in different ways. Some groups suggest that there should be dedicated funding for prevention, with targets for the share of the health budget being spent on prevention.[44] The absence of an overarching national public health strategy has been cited as one of the barriers to greater investment.[45] National leadership should also facilitate sharing resources and information about what works across the whole country.

We believe that there are three important elements or ingredients to building health promotion and prevention capacity at a national level, namely:

- committing to 10-year health goals;
- establishing a national health promotion and prevention agency; and
- financing prevention on a level playing field.

Each of these elements is now discussed.

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[38] Information on the National Prevention Summit, at: http://www.vichealth.vic.gov.au/Content.aspx?topicID=574

[39] The National Preventative Health Taskforce, at: http://www.preventativehealth.org.au/

[40] These discussion papers are available at: http://www.nhhrc.org.au

[41] Submissions and consultation reports are available at: http://www.nhhrc.org.au

[42] Australian Institute of Health Policy Studies and VicHealth (2008), A vision for prevention in Australia: Discussion paper, at: http://healthpolicystudies.org.au/component/option,com_docman/task,cat_view/gid,88/Itemid,145/

[43] T Findlay (2008), Submission 360 to the National Health and Hospitals Reform Commission.

[44] B Oldenburg and T Harper (2008), 'Investing in the future: prevention a priority at last', Medical Journal of Australia, 189(5): 267–268.

[45] L Russell, G Rubin and S Leeder (2008), 'Preventive health reform: what does it mean for public health?', Medical Journal of Australia, 188(12): 715–719.

1.6.1 Committing to ten-year health goals

Flowing from the 1981 Alma Ata Declaration, there is a long history in Australia[46] and many countries of using national health goals and targets to drive a greater focus on health promotion and prevention.

In the 1980s the work of the Australian Better Health Commission resulted in the development of a series of 20 goals and 65 targets for health promotion and disease prevention, organised by population groups, major causes of illness and death, and risk factors. It identified that the first set of priorities should relate to five areas: control of high blood pressure, improved nutrition, prevention of injury, the health of older people, and prevention of cancer (particularly lung, skin, breast and cervical cancer). The original 1988 goals were refocused following a 1993 review to emphasise four major priorities:

- Preventing morbidity and mortality;
- Addressing healthy lifestyles and risk factors;
- Ensuring health literacy and life skills; and
- Promoting healthy environments.

Over time, this approach evolved into the existing National Health Priority Areas which have a strong focus on particular diseases or health problems (such as cancer, diabetes, cardiovascular health and mental health).

The benefits of a national health goals approach have been described as providing:

> *… a rallying point for public health. Having goals and targets as a device was possibly more important than what they covered.*[47]

The United States is now developing its fourth set of decade-long goals for public health – Healthy People 2020 – to be released in 2010 (see Figure 1.6).

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[46] Discussion of the Australian experience with goals and targets is based on the following article: S Leeder (2007), Influencing public health policy and practice: the role of the public health academic, Association of Pacific Rim Universities World Institute Workshop, at: http://www.ahpi.health.usyd.edu.au/pdfs/srl07/apru260507.pdf

[47] S Leeder (2007), 'Influencing public health policy and practice: the role of the public health academic', Association of Pacific Rim Universities World Institute Workshop, at: http://www.ahpi.health.usyd.edu.au/pdfs/srl07/apru260507.pdf

Figure 1.6: Public health goals have shaped United States health policy for 30 years

In the United States, the Healthy People goals approach sets rolling ten-year national objectives for promoting health and preventing disease. This approach commenced in 1979 and work is currently underway to develop the fourth set of ten-year goals, known as Healthy People 2020, scheduled for release in 2010.

The development of these goals is highly collaborative and informed by scientific evidence. The United States Department of Health and Human Services states:

> *The Healthy People process is inclusive; its strength is directly tied to collaboration. The development process strives to maximise transparency, public input and stakeholder dialogue to ensure that Healthy People 2020 is relevant to diverse public health needs and seizes opportunities to achieve its goals. Since its inception, Healthy People has become a broad-based, public engagement initiative with thousands of citizens helping to shape it at every step along the way.*

Under Healthy People, the status of the nation's health against the goals is measured at the beginning of the decade with regular progress monitoring over the decade to identify whether the goals are going to be achieved.

Healthy People 2010 involves a cascading hierarchy of goals and targets. The two overarching goals are to increase the quality and years of healthy life, and to eliminate health disparities.

These two goals are supported by 467 objectives in 28 focus areas. There is also a smaller set of health priorities reflecting ten major public health concerns in the United States. The ten Leading Health Indicators are intended to readily convey the importance of health promotion and disease prevention to everyone. The current set of Leading Health Indicators are:

- *Physical activity – promote regular physical activity*
- *Overweight and obesity – promote healthier weight and good nutrition*
- *Tobacco use – prevent and reduce tobacco use*
- *Substance abuse – prevent and reduce substance abuse*
- *Responsible sexual behaviour – promote responsible sexual behaviour*
- *Mental health – promote mental health and wellbeing*
- *Injury and violence – promote safety and reduce violence*
- *Environmental quality – promote healthy environments*
- *Immunisation – prevent infectious disease through immunisation*
- *Access to health care – increase access to quality health care*

There is a strong focus on the Healthy People goals being used by all sections of the community. For example, toolkits and guides are available to help community groups, schools and workplaces use the Healthy Goals in their health promotion and prevention activities.

While the goals have evolved over time, there is good evidence that many of the goals set under the Healthy People approach have been met, resulting in a healthier population.

Source: United States Department of Health and Human Services, Healthy Goals website, at: http://www.healthypeople.gov/Default.htm

We believe that there is strong merit in establishing a renewed focus on health goals.

Reform direction 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.

We do not see the Healthy Australia Goals being 'delivered from above', like Moses bearing stone tablets with the Ten Commandments. There should be broad community consultation and engagement in setting the priorities for what we as a community want to achieve in better health. Many groups, including the Australian Health Care Reform Alliance, have called for greater citizen and consumer engagement in developing a common vision for our health system and a healthy population.[48] Of course, the specifics of the Healthy Australia Goals must also be informed by evidence from clinical and epidemiological studies about risk factors for poor health and effective strategies to achieve better health outcomes.

- There should be broad community consultation and engagement in setting the priorities for what we as a community want to achieve in better health

We also want to ensure that the Healthy Australia Goals don't sit, gathering dust, on people's bookshelves. One way to avoid this is to make sure that we develop a manageable number of goals – quality over quantity – so that we have the best possible chance of achieving the most important priorities we agree and set for a healthier community. Importantly, the Healthy Australia Goals should be a 'living' document. Although we have described them as 10-year goals, we envisage biennial reports to the community on progress to keep focus and commitment and to celebrate achievements or alert lack of progress. It would also be sensible to review and update the goals as new priorities may emerge or, even better, if we meet some of the goals before the ten-year timeframe has elapsed.

We were struck in reading the submissions how much our draft principles resonated with many groups and how much these principles provided an organising framework for identifying areas for improvement. We believe that Healthy Australia Goals would provide a similarly powerful framework to catalyse action on health improvement.

In the same way that we advocate a community-wide process for developing the Healthy Australia Goals, there should also be community-wide responsibility for achieving the goals. We want to emphasise that everyone can contribute to Australia becoming a healthier society. Governments have a role to play, but so do businesses, workplaces, private health insurers, community groups, non-government organisations, health services, families and individuals.

We envisage, for example, that workplaces and community groups might choose to use a subset of the national Healthy Australia Goals, identify action they can take at the local level, and measure their progress and improvement in reaching better health. Accessible information on the health of local communities, such as the wellness footprint concept and the Community Indicators Victoria data, would provide the backbone of information to support local participation in national goals on health promotion and prevention. Reporting on progress towards better health through the Healthy Australia Goals could thus occur at many levels including national, state, workplace and local communities.

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[48] Australian Health Care Reform Alliance (2008), Submission 446 to the National Health and Hospitals Reform Commission.

1.6.2 Establishing a national health promotion and prevention agency

The second element of national leadership relates to the proposed establishment of a national health promotion and prevention agency.

We are conscious that, although there is wide consensus on the need for a greater focus on prevention in our health system, the mechanisms to translate this sometimes easy rhetoric into hard reality are either lacking or underdeveloped.

The National Preventative Health Taskforce has argued that:

> *The recent history of public health in Australia shows that preventative efforts have been most effective when effective supports have been put in place ... An essential component to enable effective action is to ensure leadership and coordination through the establishment of a National Prevention Agency.*[49]

Participants, at both the 2020 Summit and the National Prevention Summit in April 2008 strongly supported the concept of a national prevention agency

Proposals for a national prevention or public health agency have been around since at least the mid 1970s. More recently, participants at both the 2020 Summit and the National Prevention Summit in April 2008 strongly supported the concept of a national prevention agency. The idea is not new – it is overdue.

We commissioned several experts to assess the models for how a national health promotion and prevention agency could be set up.[50] This included:

- examining models from other countries, Australian states and other sectors to identify the different approaches, and advantages and disadvantages of these approaches;
- identifying options for the financing and governance of a national health promotion and prevention agency; and
- outlining the range of potential functions and key objectives under which such an agency might operate.

Based on this work and our consultations, we have formed some preliminary views on the desirable features of how a new national health promotion and prevention agency might be established and operate. We believe that:

- The agency should be independent (outside government) and preferably established by statute.
- It should have reasonable funding certainty (say, on five year cycles), rather than be subject to annual appropriation processes.
- To promote broad take-up and participation in the health promotion and prevention agenda, the agency's board should be diverse (including, for example, representatives from the community, business sector and governments).
- Its scope should be cross-portfolio and across all sectors (not limited to health) reporting to the Prime Minister and the parliament.
- Its functions should include: building the evidence base for the value of health promotion and prevention; leadership, development and management of the proposed ten-year goals; undertaking social marketing and educational campaigns; and leading cross-sectoral action on health promotion and prevention.

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[49] National Preventive Health Taskforce (2008), Australia: the healthiest country by 2020, A discussion paper.

[50] R Moodie, T Harper and B Oldenburg (2008), A national agency for promoting health and preventing illness, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

We want to emphasise that national leadership on prevention and health promotion through the proposed new agency must involve a strong focus on cross-sectoral action, rather than being limited to action within the health portfolio only. Our commissioned discussion paper described this requirement as follows:

> *Much of the new national organisation's primary work would be about forging productive relationships, both with and between other key parties … Its networking activities would span governments at all levels, national agencies, professional associations, non-government organisations, the private sector, the philanthropic sector and academia. This would ensure that the transformative aspect of its work is spread from boardrooms to factory floors, from hospitals to homeless shelters.*[51]

Reform direction 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.

1.6.3 Financing prevention on a level playing field

The financing of prevention (or more accurately the absence of identified funding streams for prevention) is often raised by groups that want to see a stronger emphasis on prevention in our health system. For example:

> *The current level of investment in preventative approaches is like trying to treat a clinical outcome with half an aspirin.*[52]

The National Prevention Summit's platform for advancing prevention proposed that sustainable financing mechanisms for prevention needed to be established.[53] The summit identified some specific actions to create more sustainable financing of prevention including:

- scaling up of prevention programs that have been demonstrated to be efficient, effective and equitable;
- tasking the Council of Australian Governments with establishing a new financial framework for prevention and health promotion;
- building on experience with the use of tax-based strategies to establish health promotion foundations;
- developing transparent funding models to support prevention through new and existing financing mechanisms (such as the Medicare Benefits Schedule, hospital funding, private health insurance, taxes on unhealthy foods or alcohol);
- encouraging private sector engagement in prevention and health promotion including using price signals or tax incentives to support the provision of healthy products and funding for prevention research; and
- ensuring that government funding of health services does not introduce disincentives for health promotion and prevention.

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[51] R Moodie, T Harper and B Oldenburg (2008), A national agency for promoting health and preventing illness, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[52] Government official (19 June 2008), National Health and Hospitals Reform Commission consultation meeting with government agencies in Brisbane.

[53] Australian Institute of Health Policy Studies and VicHealth (2008), A platform for advancing the health and wellbeing of all Australians, at: http://healthpolicystudies.org.au/component/option,com_docman/task,cat_view/gid,88/Itemid,145/

To further stimulate debate on how best to finance prevention and health promotion, we commissioned two discussion papers that tackled aspects of the financing of prevention, namely:

- an analysis of the evidence on the effectiveness of using financial incentives to encourage greater personal responsibility for health[54]; and
- a paper on options to systematically fund prevention through a prevention benefits schedule.[55]

On the issue of financial incentives, the paper identified that financial incentives can be effective in increasing the uptake of preventive health programs. They work best when they are targeted to relatively simple one-off interventions (such as immunisation) and if they are used to reward positive behaviour, rather than applied as a financial penalty. We note that the issue of financial incentives was raised quite frequently during our consultation meetings, including:

> *There are no tax incentives or rebates for taking actions to keep you well. So there was a suggestion from a local Tasmanian that why couldn't we have tax rebates for families for their purchases of fresh fruit and vegetables and I guess that could be explored more.*[56]

The second paper examined the complex issues associated with the potential establishment of a prevention benefits schedule, using the analogy of the existing assessment and funding arrangements that apply for medical and pharmaceutical services in Australia. The authors recommended that clinical prevention activities (involving interactions between a health professional and an individual patient) could be funded under existing programs such as the Medicare Benefits Schedule and the Pharmaceutical Benefits Schedule. Further, they recommended that the assessment and funding of health promotion activities (involving populations) occur through separate, new arrangements.

We welcome feedback on the ideas and proposals in both these papers, noting that they represent quite ground-breaking concepts in the context of the existing Australian health system (although both have been used in other countries).

Moreover, we note that we have already proposed earlier that one of the key functions of a new national health promotion and prevention agency would be to build the evidence base. Among other areas, this evidence base could include further Australian studies on the impact of using financial incentives to encourage healthy behaviour.

At this time, we would also suggest that the proposed national health promotion and prevention agency could take the lead in collating (and sharing with relevant groups) evidence about the efficacy and cost-effectiveness of health promotion and prevention interventions. That is, our preliminary view is that the assessment of population-based health promotion and prevention interventions would be best served through a dedicated, expert agency focused solely on health promotion and prevention, in preference to being rolled into the same processes as apply for medical and pharmaceutical services. (However, we argue later in Chapter 12 that clinical prevention interventions (targeted at individuals) should be considered together with medical and pharmaceutical services under new umbrella arrangements involving the establishment of a National Health Intervention Assessment Agency.)

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[54] A Scott and S Schurer (2008), Financial incentives, personal responsibility and prevention, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[55] A Harris and D Mortimer (2008), A preventative priorities advisory committee and prevention benefits schedule for Australia, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[56] Nurse (28 May 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Hobart.

Reform direction 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.

1.7 Encouraging people to take greater responsibility for improving their own health

- Good health is clearly a personal, as well as a collective, responsibility

We turn now to the issue of individuals and how they can be supported to take greater responsibility for their own health and that of their families. Good health is clearly a personal, as well as a collective, responsibility.

Our principle on shared responsibility tackled the sometimes vexed issue of the balance between individual and community responsibility for improving health as follows:

> *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 … 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.*

Our submissions and consultation meetings highlighted the diversity of views on what was needed to allow people to take greater responsibility for their own health. They also identified that people have different capacities to take personal responsibility, with many factors (including socio-economic circumstances, educational levels and intellectual capacity) affecting the extent to which people can make meaningful choices about their health behaviours.

Figure 1.7 presents some of the ‘community voices’ on what it means to be healthy and what is needed to help individuals and families work towards better health.

Figure 1.7: People have many views about health and staying healthy

The following are some of the views of people attending our consultation meetings:

On the issue of health and wellness:

> *I think without a doubt health is really linked with happiness and appreciation of life. So if there's anything that I could suggest for being healthier it's certainly got to do with mental health and probably got to do with expectations. So if we're teaching our kids about what life really is when they're young and what to expect, then they're more likely to be satisfied and happy and healthy. (Community consultation, Sydney, 5 June 2008)*

> *Let's adopt a wellness model – let's pay incentives to keep people well and put greater funding into partnership working rather than paying for illness. This could include private health insurance rebates for wellness. (Health professional, Melbourne, 25 June 2008)*

> *The term wellness has within an implicit emphasis on those who are healthy. It should also include those with chronic illness, not just those who are able bodied. Prevention should focus on quality of life for all. (Community consultation, Melbourne, 25 June 2008)*

> *Being healthy is not just about having private health insurance or gym memberships, it is about social inclusion and connectedness as well as a work/life balance, to have time to contribute to society and the time to exercise and eat well. Group exercise classes such as Pilates and Tai Chi are a positive way to interact and stay fit at the same time. These should be offered at affordable rates for people of all ages. (Community consultation, Canberra, 23 July 2008)*

> *Spiritual life and sense of purpose is important. A balance in body, mind and spirit is needed through a society where people behave well and have an ethical basis for communication and interaction. (Community consultation, Hobart, 29 May 2008)*

On strategies to improve health and wellness:

> *Patients should be taking more responsibility for their health; there's certainly a good way to promote a healthy Australia and I believe that should be part of the key focus of the work – saying it's not to the doctors and nurses to fix you up, the patients should be encouraged to take more responsibility. (General practitioner, Alice Springs, 12 June 2008)*

> *I'd just like to see healthier food with less additives, less preservatives, that's produced for the healthiness, not for the size and not for the colour. (Health professional, Shepparton, 27 June 2008)*

> *I know one community where four potatoes costs $15, a pie costs $1.50 – what are you going to buy? (Health professional, Geraldton, 8 July 2008)*

> *I'm very concerned about the education of the young people, particularly to educate them away from drugs and alcohol because I think that we need to as a community give them all their education and support that we can. (Community consultation, Dubbo, 2 June 2008)*

> *Land use planning should contribute into the health system, particularly creating workable safe communities, where people are encouraged to walk and not to depend on cars. So the more people start walking, it will create a healthier community – particularly if they are obese, there will be other problems like diabetes, heart attack. Therefore the health system actually has to put pressure onto the planning system to create safer and healthier communities whereby people can be encouraged to walk, and also the public transport system and the land use planning should be integrated. (Community consultation, Shepparton, 26 June 2008)*

Good health is a personal, as well as a collective, responsibility. Research by the Australian Institute of Health and Welfare shows that 32 per cent of the burden of disease in Australia is due to seven risk factors which can be reduced or prevented by lifestyle and personal behaviour – factors such as smoking, obesity, physical inactivity, excess alcohol consumption and poor nutrition. The National Preventative Health Taskforce has also highlighted the interrelationship between individual responsibility for better health and the role of other groups (including governments, employers and health services) in supporting people to make healthier choices. In its discussion paper[57] the Taskforce argues that:

> *Ultimately, it is communities, families and individuals who must change behaviours if we are to become a healthier nation.*

It also observes that:

> *The solutions are not only about individual choice and personal responsibility but also about the role of governments, business and industry, and non-government organisations.*

But for many people, healthy choices are not easy choices. People have different capacities to take personal responsibility, with many factors (including socio-economic circumstances, educational levels and intellectual capacity) affecting the extent to which people can make meaningful choices about their health behaviours.

■ People have different capacities to take personal responsibility, with many factors affecting the extent to which people can make meaningful choices about their health behaviours

We have designated 'taking responsibility' as one of our four major pathways to reform. Taking responsibility involves individual and collective action to build good health and wellbeing by all parts of society – people, families, health professionals, communities, employers and governments.

Reform direction 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.

We anticipate that the National Preventative Health Taskforce will be undertaking further work on strategies that help people to make healthier choices in areas including obesity, tobacco and alcohol.

We turn now to health literacy as one of the major levers that can be used to help people take greater responsibility for their own health.

1.8 Strengthening health literacy

Health literacy is defined by the Australian Bureau of Statistics as 'the knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy'.[58]

If people are to take greater personal responsibility for their health, it is vital that they have a reasonable level of health literacy. This is especially important as people live longer with multiple health problems and chronic diseases. As the Health Care Consumers' Association of the ACT observed:

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57 National Preventive Health Taskforce (2008), Australia: the healthiest country by 2020, A Discussion paper, at: http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/discussion-technical-1

58 Australian Bureau of Statistics (2008), Australian literacy and life skills survey: Summary results, at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20(Reissue)?OpenDocument

> *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.*[59]

The evidence is clear-cut that lower health literacy is associated with poorer health outcomes

Moreover, the evidence is clear-cut that lower health literacy is associated with poorer health outcomes. Among other things, lower health literacy leads to lower rates of screening for preventable health conditions, poorer experience in managing the health of children, and difficulty in following discharge instructions.[60]

The most recent available data on levels of health literacy among the Australian population should raise serious alarm bells. The 2006 Australian Literacy and Life Skills Survey[61] of people aged 15–74 years examined health literacy, together with the following four domains of general literacy:

- Prose literacy: the ability to understand and use information from various kinds of narrative texts, including texts from newspapers, magazines and brochures.
- Document literacy: the knowledge and skills required to locate and use information contained in various formats including job applications, payroll forms, transportation schedules, maps, tables and charts.
- Numeracy: the knowledge and skills required to effectively manage and respond to the mathematical demands of diverse situations.
- Problem solving: goal-directed thinking and action in situations for which no routine solution is available.

In our complex health system, these general literacy domains are likely to be essential to understanding and navigating health services, over and above the specific domain of health literacy.

For each of the five domains of literacy (including health literacy), people were grouped into one of five 'skill levels', corresponding to their proficiency. People at Level 5 are classed as having the best literacy, while people at Levels 1 and 2 are assessed as having such a low level of proficiency that they would be unable 'to meet the complex demands of everyday life and work in the emerging knowledge-based economy'. About half the population lack basic proficiency in the literacy domains of prose, documents or numeracy (see Figure 1.8). Three out of every five adults lack basic proficiency in health literacy – they do not have the skills to equip them to manage their health and health problems.

In considering how to tackle this major challenge of low health literacy, we believe that one major approach must involve equipping children and young people with better skills to understand their health and how to use the health care system. As we discuss later in Chapter 3, we believe that a healthy start to life is a vital investment in working towards a healthier population. Investment in the health of children and young people (and their families) should include a focus on health promotion to encourage good nutrition and healthy lifestyles. We further believe that this approach needs to be extended to promote better health literacy.

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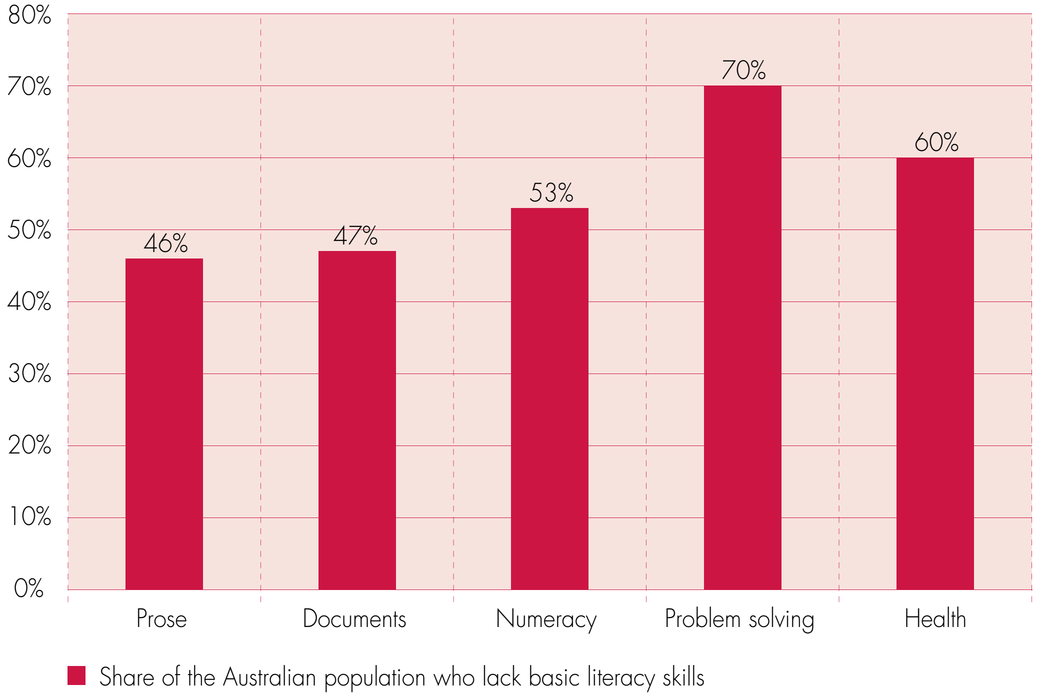
[59] Health Care Consumers' Association of ACT (2008), Submission 89 to the National Health and Hospitals Reform Commission.

[60] Agency for Healthcare 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

[61] The analysis in this section is based on: Australian Bureau of Statistics (2008), Australian literacy and life skills survey: Summary results, at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20(Reissue)?OpenDocument

Figure 1.8: Many Australians lack basic general literacy and health literacy skills



Source: Australian Bureau of Statistics (2008), Australian literacy and life skills survey: Summary results, at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20(Reissue)?OpenDocument

Note: This is based on the proportion of the population who are classified as having only Level 1 or Level 2 literacy skills and do not meet the minimum standards required for everyday life and work.

Reform direction 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.

An expanded focus on health literacy in our schools was supported in a number of our submissions. CHOICE argued for a similar approach to be adopted for health literacy as has occurred with financial literacy.[62] In 2006, the Commonwealth Government provided $21 million to establish the Financial Literacy Foundation to undertake research and develop programs to raise the level of financial literacy. The Understanding Money website allows people to take a ‘financial health check’ and develop budgets.[63] Another element of the foundation’s program is working with schools so that financial literacy is included in the curriculum from Kindergarten to Year 10 from 2008. It is difficult to argue that our physical and mental health should not be at least as important as our financial health, even in a time of international financial instability.

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[62] CHOICE (2008), Submission 63 to the National Health and Hospitals Reform Commission.

[63] Understanding Money, at: http://www.understandingmoney.gov.au/

There is a need for life-long learning to support people in making informed choices about their health

While early education and skills development on health literacy is vital, we also recognise that there is a need for life-long learning to support people in making informed choices about their health. Information overload may be a truism, but it also reflects how many of us feel when confronted with the difficult task of finding the 'right' information to help us make decisions about our health and use of health services. Through our submissions and consultations, we learned of many valuable information sources and tools that can help people access and use high quality health information including:

- The National Breast and Ovarian Cancer Centre [64] provides an online risk calculator that 'translates the evidence about risk factors for breast cancer into a meaningful tool for individuals'. Women answer a series of questions to better understand their personal risk of breast cancer and lifestyle choices that they can make to reduce their risk.
- Lab Tests Online Australasia[65] provides peer-reviewed information that is targeted to consumers about the purpose of hundreds of pathology tests including what tests are used to diagnose particular conditions. For example, consumers can find detailed information about cholesterol testing, including how the test is done, what the findings mean and treatment and lifestyle change options.
- The Media Doctor Australia website[66] has been developed by a team at the University of Newcastle to improve the accuracy of medical news reporting. The site assesses current news items about medical treatments, presenting examples of good and bad coverage, using a robust rating scale with the aim of improving 'journalistic practices in reporting new medications and treatment in Australia'.

Many non-government organisations also offer high-quality online information related to particular diseases, such as heart disease, diabetes or cancer. The Commonwealth and state governments also provide access to reliable health information, often on specifically tailored consumer sites, and sometimes facilitate access to people whose first language is not English.

It would be naïve to assume that the vast array of potentially valuable information about health on the web could be organised and navigated through a single site. There are so many diverse needs for often highly specific information and so many groups able to contribute to providing, filtering and interpreting health-related information. Health information is everybody's business, in the same way that health is everybody's business.

We recognise that there are many channels by which people continue to learn and acquire information on health throughout the course of their lives. These include online resources, friends and family, the media, their GP and other health care professionals, community groups, private health insurers, and governments. Each of these has a role to play in ensuring that people have access to the best possible information to make healthy choices.

Reform direction 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.

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[64] National Breast and Ovarian Cancer Centre (2008), Submission 122 to the National Health and Hospitals Reform Commission. The online risk calculator is at: http://www.nbocc.org.au/risk

[65] National Coalition of Public Pathology (2008), Submission 123 to the National Health and Hospitals Reform Commission. The online pathology test information site, customised for Australia, is at: http://labtestsonline.org.au/

[66] The Media Doctor Australia, at: http://www.mediadoctor.org.au/

CONNECTING CARE

COMPREHENSIVE CARE FOR PEOPLE OVER THEIR LIFETIME

ITERACY ACCESS CAPACITY **CONNECTING CARE** INNOVATION EVIDE
HEALTHY START PRODUCTIVITY WELLNESS EVERYONE LEADERSHIP COM
CHOICES FAIRNESS RESPONSIBILITY ACCOUNTABILITY RESPECT VALUES
CARE FOR LIFE **FACING INEQUITIES** PEOPLE AND FAMILIES HEALTH LITERA
ACCESS CAPACITY INNOVATION EVIDENCE CARE FOR LIFE PRODUCTIV
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COMMUNITY CHOICES FAIRNESS RESPONSIBILITY ACCOUNTABILITY RE
VALUES HEALTHY START PEOPLE AND FAMILIES HEALTH LITERACY ACCES
CAPACITY INNOVATION EVIDENCE CARE FOR LIFE PRODUCTIVITY WELL
CARE FOR LIFE **TAKING RESPONSIBILITY** PRODUCTIVITY WELLNESS EVERY
QUALITY LEADERSHIP COMMUNITY CHOICES FAIRNESS RESPONSIBILITY

2. Creating strong primary health care services for everyone

Key messages

- Primary health care is the gateway for people to health services. Almost everyone uses a primary health care service at least once a year.

- There is compelling international evidence that demonstrates the benefits of strong primary health care services in improving health outcomes for people. Transformed primary health care services – comprehensive, visible and accessible – should be acknowledged as the preferred primary source of care.

- Primary health care services must be able to respond to the changing health needs of people throughout their lives, ranging from child and family health services to promote early childhood development and wellbeing, to coordinated care for people with chronic diseases, and to support for frail older people to remain living in their own homes.

- A strong primary health care foundation is vital to driving quality performance through ensuring the 'right care in the right setting'. This includes reducing avoidable hospital visits and admissions through a focus in primary health care on early intervention and self-management.

- Rebates for fee-for-service medical care provided by general practitioners work well for most people who require episodic care and should be retained.

- Across our life journey, we have different health needs at different times. A major stage of the life cycle is the birth of our children. Another occurs with the development of chronic diseases as we age. Care for the chronically ill can require a broader range of health services than medical care, provided in a connected way over time. To address these major life cycle challenges, Medicare needs to be further expanded beyond medical care to support access to a wider range of health professionals in primary health care, using funding approaches that are better suited to care over an extended time.

- We currently do not have an Australia-wide network of large primary health care organisations that meet people's needs through a wide range of services and extended hours. Larger centres can support a larger and more diverse team of primary health care professionals and can be more convenient for people needing care because they can access more of the services they need in one place.

Our reform directions

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.

> *Primary health care reform is the single most important strategy for improving our health, and making the system sustainable. Community-level prevention and primary health care is essential to restoring universalism and efficiency in Australian health care.*[1]

Primary health care must be the foundation of our future health system.

- Primary health care is the cornerstone of our 'connecting care' theme

Primary health care is the cornerstone of our 'connecting care' theme. This is why we begin our examination of the health service system with primary health care. When we think about 'connecting care', we need primary health care to be the connecting link as people move back and forth between using other health services, such as hospitals, specialists and sub-acute services. While we consider issues related to improving other parts of the health service continuum in Chapters 3 to 7, we want to emphasise that all these other health services depend upon, and must connect people back to, strong primary health care services.

Primary health care should also provide the 'connection' across our lifetime. While we may have needs for different specialised health services as we age, primary health care should be our 'home base'.

Strong primary health care, as the front line of Australia's health system, is integral to our vision of people- and family-centred care. It is central to keeping people well, not just looking after them when they are sick.

2.1 Defining and scoping primary health care

There are many definitions of primary health care, including from the World Health Organization.[2] Others have suggested that there is 'no absolute or consistent view about whether particular settings and services are part of primary health care or not'.[3] At the same time, primary health care as the point of first contact appears to be a consistent theme.

For the purposes of this report:

Primary health care means 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 all other registered practitioners. It includes community mental health, domiciliary nursing, maternity and early childhood, sexual and reproductive health, alcohol and drug treatment services, young people's services, school health and other services.

International evidence shows that the strength of primary health care is associated with better health outcomes for the population and the containment of growth in overall health system costs.[4] Health systems that include strong primary medical care are more efficient and have lower rates of hospitalisation.[5] This has also been demonstrated at the local level in Australia.[6] At the same time, lower use of hospitals and greater patient satisfaction with all care is associated with continuity of care with the same primary care provider or service.[7]

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[1] J Doggett (2007), A new approach to primary health care for Australia (Centre for Policy Development: Sydney)

[2] World Health Organization (1978), Declaration of Alma-Ata, at: http://www.euro.who.int/AboutWHO/Policy/20010827_1

[3] Department of Health and Ageing (2008), Towards a National Primary Health Care Strategy: A discussion paper from the Australian Government (Commonwealth of Australia: Canberra).

[4] B Starfield (1995), Is strong primary care good for health outcomes? The future of primary care (Office of Health Economics: London).

[5] M Harris, M Kidd and T Snowdon (2008), New models of primary and community care to meet the challenges of chronic disease prevention and management, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[6] Cobram District Hospital (2008), Submission 64 to the National Health and Hospitals Reform Commission.

[7] M Harris, M Kidd and T Snowdon (2008), New models of primary and community care to meet the challenges of chronic disease prevention and management, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

In Australia the primary health care sector comprises a broad array of Commonwealth and state government funded programs, and government and privately-provided services. There are several primary health care models:

- general medical practice (general practice) which is largely Commonwealth funded, and multidisciplinary teams funded predominantly by states;
- private allied health professionals who are mainly funded directly by households and private health insurers;
- community health services that may be supported by either local or visiting salaried general practitioners, medical specialists, and specialist consultants or stand-alone nursing services;
- community health programs funded by the Commonwealth and state governments that are aimed at population groups with high needs including low income people, people with a mental illness, people with new babies, the frail elderly, people with disabilities, and people living in rural and remote areas; and
- child and maternity services that are a combination of Commonwealth, state, and private providers.

2.2 Building on our strengths

In designing a new model for primary health care, we believe that it is important we retain and build on the elements that are already working well.

Some of these strengths include:

- universal access to rebates against the cost of medical visits and pharmaceutical coverage (Medicare and the Pharmaceutical Benefits Scheme);
- a robust general practice sector respected by consumers, noting there are access and coverage issues for some parts of the Australian community;
- a robust community health sector, including maternal and child health;
- successful prevention activities such as immunisation;
- excellent training in medical, nursing and allied health; and
- strong innovation in rural, remote and Aboriginal and Torres Strait Islander people's health.

In addition, there has been a range of positive initiatives that have begun to tackle some of the areas where primary health care does less well. They include programs to extend access to allied health services and care planning, and promote more effective patient self-care; and programs to support service coordination, including investment in an electronic patient health record.

2.3 Identifying the case for change

There are many people who are passionate about reforming primary health care. We commissioned some of them to give us their ideas about what primary health care should look like in 2020 and these discussion papers are available on our website.

There are real opportunities to reform and strengthen primary health care ■

Many of our submissions and national consultations identified that there are real opportunities to reform and strengthen primary health care (see Figure 2.1). Areas identified include: an increased focus on prevention and wellness; multidisciplinary care to promote continuity of care while also being complementary to general practitioner care; 'one-stop shops' that provide comprehensive, accessible, affordable and reliable care; and visible and accessible services for consumers.

The issue of navigating the system was raised in one of our invited discussion papers:

> *Care pathways through primary care are confusing and often poorly supported, leaving the client to find their way through the maze of overlapping services and past the gaps in service.*[8]

Figure 2.1: National consultations across Australia – frequently raised issues and suggestions to reform primary health care:

Frontline health professionals	• *increased focus on prevention and wellness* • *patient enrolment* • *shared care arrangements and service integration to improve continuity of care and support for people and families with complex needs* • *workforce redesign and enhancement or substitution* • *greater flexibility to focus on regional priorities with resourcing for holistic needs of local communities* • *rebates for telephone and online consultations and broader coverage of health professions and activities by MBS and PBS* • *access via one-stop shops in primary health care* • *gaps, duplication and overlap in services* • *benefit of one system*
Community groups	• *access to holistic patient-centred care with consumers as partners* • *support for carers* • *information to enable informed choices about health and treatment* • *appropriate care for vulnerable and minority groups* • *improved transport and infrastructure* • *improved access to after hours care* • *focus on wellness, prevention/healthy lifestyle/self-management* • *multidisciplinary care to facilitate continuity of care and as an alternative to general practitioners for certain issues* • *one-stop shops that provide accessible, affordable and reliable care* • *the need for an accessible system easily navigated by consumers*

Source: National Health and Hospitals Reform Commission, National Consultations, May to July, 2008

Reform to primary health care is also the vital platform for reforms in areas such as chronic disease management, mental health, prevention and a healthy start to life.

One of the major reasons why we need to ensure that we have access to high quality primary health care services is the increasing number of Australians suffering from chronic conditions.

Current trends indicate that, by 2020 and beyond, more of Australia's population will be older and more people will have chronic conditions. Primary health care services are experiencing substantial pressure due to the growth in chronic illness. For example, recent research into the prevalence and patterns of multimorbidity (people with several health problems) in Australia has indicated that about three in ten people who saw a general practitioner in 2005, and one in four Australians, have two or more types of chronic conditions.[9] Among the elderly, 83 per cent of the surveyed patients had multiple conditions which have a negative impact on their quality of life and increases health service use.

■ Reform to primary health care is also the vital platform for reforms in areas such as chronic disease management, mental health, prevention and a healthy start to life

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[8] S Dunn, I Ellis, D Jones and A Murray (2008), New models of Primary Care, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[9] H Britt and colleagues (2008), 'Prevalence and patterns of multimorbidity in Australia', Medical Journal of Australia 189 (2): 72–77.

In 2007-08, chronic conditions had risen to 52.3 per cent of general practice conditions

In 2007–08, chronic conditions had risen to 52.3 per cent of general practice conditions.[10] The anticipatory care needed for early and better management of people with chronic diseases can only be provided by the primary health care team. Effective management of people with chronic illness requires continuity of care, and the use of a multidisciplinary team, which needs to work effectively together, with defined care pathways, and a cohesive funding system. As a health professional in one of our consultation forums commented:

> *Medicare does not recognise long visits – it encourages 'six minute medicine'. Complex cases are supposed to need a complex care plan, but what about the person coming in with six different problems? Are we supposed to make them come in for three or four separate visits and cost the system even more?*[11]

There is emerging evidence that quality of care needs addressing. For example, preventive activities are not currently considered as key elements of current general practitioner care. Only 34 per cent of general practitioners, when surveyed, provided smoking cessation advice in consultations with smokers.[12] Moreover, 'in 2005–6, only one in five problems in general practice were managed using non-pharmacological interventions and, out of these interventions, only 1.2 per cent were for smoking, 9 per cent for nutrition/weight, 0.7 per cent for alcohol, and 2.9 per cent were for exercise counselling.'[13]

In one of our invited papers on reform of primary health care, Mark Harris, Michael Kidd and Teri Snowdon have argued that there is now greater pressure on the care relationship between families and their general practitioner:

> *General social changes including commodification of health care, widespread access to the web based information technology, increased medical workforce participation by women, increased mobility of the community and longer working hours have put greater pressure on the care relationship between families and their family practitioner. It is more difficult for a GP to be available at all times when families might need care. The informal linkage between a GP and their practice population has become more tenuous as personal continuity has decreased as has capacity to make best use of new internet based services.*[14]

At the same time, our primary health care system has a wide range of programs and services with a variety of financing arrangements. Often consumers find that it is fragmented and uncoordinated, with care at multiple locations with differing forms of payment, which reduces efficiency and creates greater potential for errors and duplication.[15] In our national consultations, people expressed the need for improved health system navigation and care coordination so that service delivery would be simplified.[16]

Other diverse factors contributing to the case for primary health care reform include the pressures on acute hospitals, the consumer preference to be treated closer to home, the issue of access to primary health care by people living in residential aged care settings, and the relationship of primary health care to other settings. For example, it is well known that a sound working system of primary health care means avoidable hospitalisations.

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[10] C Bayram, H Britt and J Charles (2008), General Practice activity in Australia 1998–99 to 2007–08: 10 year data tables, at: http://www.aihw.gov.au/publications/gep/gpaia98-99-07-08-10ydt/gpaia98-99-07-08-10ydt.pdf

[11] Health professional (8 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Geraldton.

[12] J Young and J Ward (2001), 'Implementing guidelines for smoking cessation advice in Australian general practice: opinions, current practices, readiness to change and perceived barriers', Family Practice (18):14–20.

[13] E Britt, G Miller and colleagues (2007), General Practice Activity in Australia 2005–2006 (Australian Institute of Health and Welfare: Canberra).

[14] M Harris, M Kidd and T Snowdon (2008), New models of primary and community care to meet the challenges of chronic disease prevention and management, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[15] J Doggett (2007), A new approach to primary health care for Australia (Centre for Policy Development: Sydney).

[16] For example, Health professional (28 May 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Hobart.

In the words of one of our submissions:

> *It should eventually be a shameful experience to end up in an acute setting from a preventable illness or injury. The whole of the community should own the shame. We must find a way to articulate the preventable status of each de-identified patient and allocate resources in the community based on this ranking.*[17]

One other important issue – the need to improve the responsiveness and access to primary health care services for older people living in residential aged care services – is examined later in Chapter 6.

Finally and importantly, we must acknowledge that primary health care is organised quite differently across the country, with implications for the types of services that people are able to access. People living in metropolitan, regional, and large rural areas are likely to be able to access primary health care services that are privately provided (such as GPs and allied health services). People living in small rural and remote communities are more likely to have care provided by the resident remote area nurses with visiting support provided by salaried general practitioners. In Aboriginal and Torres Strait Islander communities, primary health services are provided through community controlled health services and Aboriginal health workers. Some rural and remote communities have little or no general practitioner support, and non-government, not-for-profit organisations are more prominent providers in rural and remote areas. We return later to the issue of how to ensure access to primary health care services in areas of market failure, such as remote communities where existing models do not support access to a general practitioner.

2.4 Creating a better future

In reforming primary health care, we have been influenced by the life course approach to health, which focuses on how health develops over an individual's lifetime.[18] Key concepts are:

- Health is developmental – health development is a process of age-related changes in functional status over the life course. Experiences at the beginning of life relate to functional outcomes during the middle and end of life.
- An individual's health status and wellbeing is a consequence of multiple determinants operating in nested genetic, biological, behavioural, social, and economic contexts that change as a person develops.
- Health development is a lifelong adaptive process with interactions across each of the determinants that influence health.
- Different health trajectories are the product of dynamic, lifelong interactions between risk, protective, and health-promoting influences.

A life course approach emphasises a more comprehensive and holistic approach to optimising health development, with a greater focus on prevention and health promotion:

■ A life course approach emphasises a more comprehensive and holistic approach to optimising health development

> *Life-course health policy is essentially prevention policy with the longest time horizon possible: from conception to death.*[19]

It organises care around longer and more developmentally appropriate time frames, and targets long-term functional capacity rather than short-term disease outcomes.

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[17] T Findlay (2008), Submission 360 to the National Health and Hospitals Reform Commission.

[18] N Halfon and M Hochstein (2002), 'Life course health development: An integrated framework for developing health, policy, and research', Millbank Quarterly 80 (3): 433–79.

[19] C Forrest and A Riley, 'Childhood Origins of Adult Health: A Basis for Life-Course Health Policy', Health Affairs 23 (5):155–164.

The developmental and broad nature of health requires strategies for appropriate vertical, horizontal, and longitudinal integration to enable the health system to optimise health development:

- Vertical integration covers primary health care, specialist care, and hospital and sub-acute services.
- Horizontal integration recognises the interdependence of physical, mental, developmental, and oral health services.
- A longitudinally integrated system is organised around developmentally sensitive services, anticipatory guidance, and delivery pathways that optimise transitions.

Transformed primary health care services – with a focus on comprehensive, integrated care – would provide the foundations for a life course approach that supports the optimal health of a person through the critical and sensitive periods of development and ageing over the life course. They would respond to the changing health needs of people throughout their lives, ranging from child and family health services to promote early childhood development and wellbeing, to coordinated care for people with chronic diseases, and to support for frail older people to remain living in their own homes.

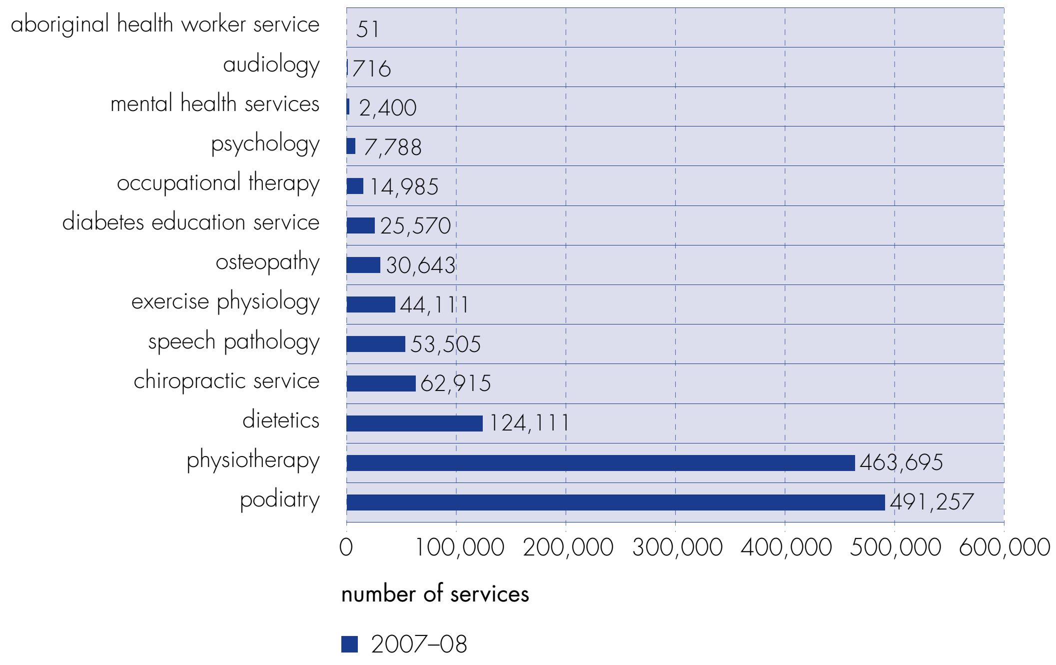
To build primary health care services that aim to optimise health development throughout the life course, we are proposing nine reform directions, discussed further below:

- integrating and strengthening primary health care nationally;
- supporting comprehensive health care through Comprehensive Primary Health Care Centres;
- providing access to multidisciplinary care;
- embedding a strong focus on quality and health outcomes across all primary health care services;
- managing care of people with chronic and complex conditions through shared care arrangements;
- improving service coordination and population health planning priorities at the local level;
- improving access to care;
- providing quality primary health care services for Aboriginal and Torres Strait Islander peoples wherever they are; and
- promoting personal control of health information.

2.4.1 Integrating and strengthening primary health care nationally

The Commonwealth is already the major funder of primary health care – for example, general practice through the Medicare Benefits Schedule (MBS), and allied health and other community-based ancillary services through the private health insurance rebate. Recent policy decisions have extended the coverage of payments under the MBS to provide some coverage for almost all registered health professionals in caring for chronic and complex disease. The new care planning item numbers now allow access to a range of allied health practitioners including psychologists, podiatrists, physiotherapists, and chiropractors (see Figure 2.2).

Figure 2.2: Allied health services funded by MBS under the Enhanced Primary Care Program



Source: Medicare Australia (2008), at: https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml

At the same time, over ten million Medicare item numbers involving practice nurses have been claimed in the last four years. Almost 60 per cent of practices have a general practice nurse with their roles including, for example, prevention, chronic disease management, and health assessments.[20]

We signalled in our first report, *Beyond the Blame Game*, our view about the desirability of the Commonwealth Government assuming responsibility for the full range of primary health care services. We continue to hold this view. For primary health care to be the platform for universal access to health services, there needs to be national leadership to strengthen primary health care and bring together the broader community health services and general practice to form larger or virtual comprehensive primary health care services. This leadership on primary health care reform can only come from the Commonwealth Government. The multiple health professionals and programs that currently make up primary health care need to be integrated under a coherent national policy and funding framework.

- This leadership on primary health care reform can only come from the Commonwealth Government

Reform direction 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.

This reform direction means that the Commonwealth will have an active leadership role in ensuring the adequacy and distribution of the full range of primary health care services for consumers.

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[20] Australian Practice Nurses Association (2008), Submission 42 to the National Health and Hospitals Reform Commission.

Under this reform direction, the Commonwealth will become responsible and accountable for all government funding of community health services including state and territory and non-government services such as generalist community health centres. This will include funding responsibility for specialised services such as alcohol and drug treatment services, sexual and reproductive health services, young people's services, school health, maternal and child health services, and the like. The assumption by the Commonwealth of responsibility for all primary health care would require a matching transfer of funds from states and territories to the Commonwealth, estimated to be about $3 billion.

We further note that in designing a model to underpin future primary health care, there should be a mix of funding including:

- continued use of fee for service;
- some capitation payments;
- some payment for performance and quality;
- some regional grants; and
- some grant funding for primary health care services for other than medical clinical services.

Single responsibility for primary health care will mean the Commonwealth will be in a better position to take charge, fund properly, drive to achieve policy outcomes, and be accountable for equity across Australia.

2.4.2 Supporting comprehensive health care through Comprehensive Primary Health Care Centres

Across our life journey, we have different health needs at different times. A major stage of the life cycle is the birth of our children. Another occurs with the development of chronic disease as we age. Care for chronically ill people can require a broader range of health services than medical care, provided in a connected way over time. To address these major life cycle challenges, Medicare needs to be further expanded beyond medical care to support access to a wider range of health professionals in primary health care, using funding approaches that are better suited to care over an extended time. At the same time, we need Comprehensive Primary Health Care Centres to meet these challenges.

To deliver a wider range of services, locations/facilities for the delivery of primary health care need to become larger. Larger centres can support a larger and more diverse team of primary health care health professionals, are better able to invest in support infrastructure such as clinical information systems, and can open for extended hours using rosters that do not require professionals to be on duty every second night of the week, and support clinical training. They can also be more convenient for people needing care, enabling them to access more of the services they need in one place, without the need to coordinate their information and appointments across several different providers in different locations.

We heard considerable support for this concept of a 'one-stop shop' through a number of our submissions[21] and in the national consultations. This will involve the appropriate mix of public and private health service provision:

> *Private hospitals are a vital and complementary partner to the larger public sector in the provision of a wide range of services and contribute significantly to the balance and sustainability of the Australian health system.*[22]

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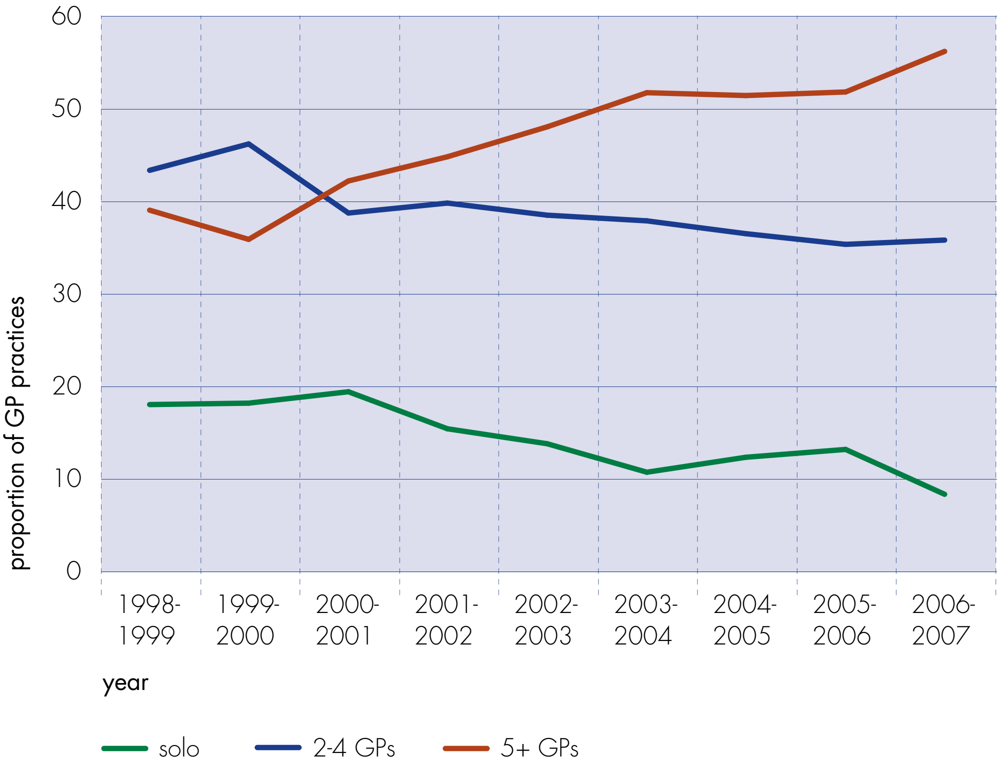
[21] For example, Centre for Policy Development (2008), Submission 60; Plenty Valley Community Health (2008), Submission 146; Aged Care Association (2008), Submission 440 to the National Health and Hospitals Reform Commission.

[22] Australian Private Hospitals Association (2008), Submission 10 to the National Health and Hospitals Reform Commission.

Although general practices have been growing in size in recent years (see Figure 2.3), it is a trend that needs further strengthening. In 2006–07, over 50 per cent of practices consisted of five or more general practitioners but 30–40 per cent were still in smaller practices of between two and four practitioners.

Figure 2.3: More than half of general practices have five or more full-time equivalent general practitioners.



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

We want to see the widespread formation of Comprehensive Primary Health Care Centres in most local communities.

Reform direction 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.

Our preliminary views about the possible features of such Comprehensive Primary Health Care Centres are as follows:

- The centres could provide a range of services to become 'one-stop shops' for medical and non-medical services including general practitioners; secondary care; co-located diagnostic services – pathology collection and diagnostic imaging – nursing and other health professionals; with proximity to pharmacy.
- The centres could have the skills and facilities for urgent care such as suturing, plastering, and minor procedures.
- Centres could generally be open extended hours – for example, from 6 am to 10 pm.
- There could be agreed protocols with local hospitals for swift transfer of patients who present to a Comprehensive Primary Health Care Centre but who require emergency care, specialist assessment, or admission.
- Comprehensive Primary Health Care Centres could have established arrangements with local home care providers to ensure coordinated delivery of care to clients, and to avoid unnecessary hospitalisation.
- Comprehensive Primary Health Care Centres could be encouraged to enter into arrangements with local residential care facilities to provide visiting and on-call medical and allied health services to residents.
- Embedding the strategy of ensuring a healthy start to life for all children will require child and family services to be co-located in the Comprehensive Primary Health Care Centres or linked by a nurse if child and family services stand alone (see Chapter 3).
- Comprehensive Primary Health Care Centres could be encouraged to establish through the offer of initial fixed capital grants on a competitive basis. Criteria for selection could include the range of services to be offered, size, commitment to meet minimum opening hours, and evidence of established partnerships with local hospitals, home and community care providers, and aged care services. Also, consortia to be eligible would need to involve current medical and allied health providers and community participation in planning. Importantly, they would be expected to have a role in the training and education of the next generation of primary health care professionals.

It is vital that the implementation of the proposed Comprehensive Primary Health Care Centres involves all local stakeholders and the community

■ We believe it is vital that the implementation of the proposed Comprehensive Primary Health Care Centres involve all local stakeholders and the community.

We note that among the submissions and the commissioned papers on primary health care reform, there have been models identified to improve the organisation and delivery of primary health care. Some of the successful working concepts included in such models may also be relevant to the establishment of Comprehensive Primary Health Care Centres (see Figure 2.4).

Figure 2.4: New South Wales is developing new models of primary health care involving community hubs

__HealthOne Mt Druitt__ is located at Mt Druitt Community Health Centre in a purpose built 'hub' extension to the facility. Its service model is based on a 'hub and spoke' virtual service approach. It brings together GPs, community health staff and other service providers involved in the care of identified clients to facilitate communication between providers, support care planning and coordination.

Its core service components include: criteria-based enrolment system; agreed care partnerships; designated care communicator; case conferences; co-case management; agreed care plan; and multi-levels of service provision.

Two GP liaison nurses employed by community health (one for chronic, aged and complex care; and for child and family) are the linchpins of the model as they identify clients needing care coordination and link GPs and other service providers.

The HealthOne Mt Druitt hub functions as a resource and planning base and a central point for multidisciplinary assessments and case reviews, plus the delivery of a range of service clinics including the complex wound clinic; child and family health clinic; falls clinic (in development); and antenatal clinic (in development).

Outreach clinics are also planned at identified isolated locations which do not have ready access to GPs and other health service providers.

Target population groups include people with complex and chronic conditions; frail aged; families with children where there are vulnerabilities/at-risk factors; young people with health needs including mental health; and people in the community who have difficulty accessing services due to disadvantage or isolation

Source: New South Wales Department of Health (2008), HealthOne Mt Druitt, at: http://www.health.nsw.gov.au/Initiatives/HealthOneNSW/sl_mt_druitt.asp

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2.4.3 Providing access to multidisciplinary care

In the future, we will need a primary health care model that provides the right match and mix of services, rather than a 'one size fits all' approach. While universal access under Medicare has served us well, it does not necessarily ensure that people with the highest needs get access to the best range of health care services.

We have already noted that we have different health needs at different times, with particular needs at particular times. For example, it is important for young families to have ready access to a primary health care service with multidisciplinary clinical services. In this way, the right mix of services, together with continuity and quality of care, can be assured.

In general, people with chronic and complex care needs require continuity of care, over time, from health care professionals who are familiar with the history of their condition or conditions and their treatment. It is unsurprising that most older people, who generally have a higher prevalence of chronic conditions, also tend to stay with a single general practice.

We would like to strengthen the relationship between patients and primary health care services through voluntary 'signing up' or enrolment. One of our invited papers saw the benefit of enrolment for consumers as being:

- We would like to strengthen the relationship between patients and primary health care services through voluntary 'signing up' or enrolment

> *… to enhance access to multidisciplinary preventive and chronic disease care and make primary care organisations accountable for this.*[23]

The concept of voluntary enrolment is strongly supported in a number of submissions[24], including the joint submission from General Practice Queensland and Queensland Health[25] which suggests a more integrated, multidisciplinary approach to prevention and management of chronic disease, including voluntary patient enrolment. The submission from the Royal Australian College of General Practitioners stated:

> *To help general practices better manage complex clinical cases, and to create accountability for community health, the RACGP supports the exploration of a voluntary patient register in which patients can identify their preferred general practice. Both patient and doctor should then be provided with incentives for the management of the whole person needs of people enrolled.*[26]

We believe that voluntary enrolment will fund more coordinated and innovative models of care including the development of care pathways, self-management programs, carer support and video and telephone support.

We are of the view that early childhood services are fragmented, with little efficient and effective communication between the health service providers (see Chapter 3). These services are complex and include Commonwealth, state and territory governments, and private providers.

We support better training of health professionals to ensure they can cater for the needs of people with disabilities ■

We are also concerned that children and adults with disabilities, and families with special needs, fall through the 'health service gaps' with resulting long delays in accessing services and poor coordination of care. It is our view that formal voluntary enrolment with a Comprehensive Primary Health Care Centre will foster the total care of children and their families over the life journey. At the same time, we support better training of health professionals to ensure they can cater for the needs of people with disabilities.

The proposed features of how a voluntary enrolment model might work include:

- People with chronic and complex care needs, and people with particular care needs, including expectant mothers and parents with young children (and their children), would be able to choose to enrol with a service.
  - For those enrolling, enrolment means that they will have chosen to get all their primary health care from that practice except in limited circumstances such as when they are away from home. Practices/services would be able to choose whether or not to participate in the program.
  - Patients could, however, elect to shift to another practice/service after a specified period.
- Primary health care services would receive additional funding in proportion to the number of people they enrol, and the chronic conditions or particular care needs that those people have, and the outcomes the practice achieves.
  - They could use the funds to engage nurses and other registered health professionals to work in the service to provide a broader range of services to their enrolled clients. Primary health care services may also use some of the funds to acquire infrastructure such as clinical information and practice management systems to support care delivery, and non-clinical support staff to assist in managing the service.
  - As an alternative to in-house staff, a practice could choose to have arrangements with nearby independent allied health practitioners, and maternal and child health and community health to provide services to the practice's enrolees.

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[23] M Harris, M Kidd and T Snowdon (2008), New models of primary and community care to meet the challenges of chronic disease prevention and management, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[24] For example, Australian General Practice Network (2008), Submission 34; SA Health (2008), Submission 458; Primary Health Care Research and Information Service (2008), Submission 148 to the National Health and Hospitals Reform Commission.

[25] GP Queensland and Queensland Health (2008), Submission 209 to the National Health and Hospitals Reform Commission.

[26] Royal Australian College of General Practitioners (2008), Submission 511 to the National Health and Hospitals Reform Commission.

  - Doctors would remain on fee for service.
- Practices would compete for enrolees by the expanded services they offer and their responsiveness in meeting the needs of their enrolees.
- People could change the practice with which they are enrolled at any time. Enrolments would be notified to Medicare Australia, which would calculate the grants that a practice receives based on the enrolee profile for the quarter.
- There would be no compulsion for people to enrol, and there would be no compulsion for practices to seek enrolees – practices may choose to remain as fee for service, and people could continue to see multiple general practitioners as they choose.
- Participating practices would be required to capture and provide data including Medicare card number to Medicare Australia on all services provided to enrolees including for grant-funded services.
- Participating practices would also be required to produce a greater range of data on the coordination of enrolled practices.
- This model would foster alternative models of service contact including email, telehealth phone consultations, telephonic health coaching from professional call centres, or from the practice itself for telephone/online advice – for example, Map of Medicine (see Chapter 15) and Health Dialog.

We expect that enrolment would promote continuity of care, allow appropriate measurement of the quality of care provided, allow for identification of needs in a local environment, and would, over time, allow the development of the building of capacity and sustainability in primary health care.

■ We expect that enrolment would promote continuity of care

Reform direction 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 practice tied to levels of enrolment of young families and people with chronic and complexconditions.
- 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.

In considering enrolment for people with chronic and complex conditions, it is likely that this could include a broad range of conditions. For example, it would include people with chronic mental health problems, people with an intellectual disability or a degenerative condition, as well as people with chronic diseases such as diabetes. The identification of this category relates to whether patients would benefit from the enhanced continuity and coordination of care that would be expected to be achieved through voluntary enrolment.

We believe that, over time, there could also be consideration of a model of voluntary enrolment that applies to all consumers, carers and their families.

2.4.4 Embedding a strong focus on quality and health outcomes across all primary health care services

> *The meteoric rise in the prevalence of chronic disease in Australia owes as much to our lifestyle as the ageing phenomenon …. The health system of the future must broaden its scope to include such measures and promote personal responsibility for lifestyle.*[27]

Primary health care has a key role in delivering prevention and wellness strategies

Primary health care has a key role in delivering prevention and wellness strategies. Many hospital admissions could have potentially been avoided if timely and adequate care in the community had been provided; for example[28], in the case of:

- acute conditions which may not be preventable but would not result in hospitalisation if care was received at the right time;
- chronic conditions which may be preventable through behaviour modification, falls prevention and lifestyle change, but can also be managed through timely care to prevent deterioration and hospitalisation;
- vaccine preventable diseases; and
- medication adverse events (approximately $6 billion in hospitalisation).

Recent Medicare reforms acknowledge the primary health care role in prevention and wellness with new Medicare Preventive Health Care items such as the facilitation of early intervention strategies through the Healthy Kids Check Medicare items, and a Type 2 Diabetes Risk Evaluation Medicare item.

We support introducing new MBS item numbers for preventive activities in primary health care where appropriate evidence, including economic value, has been established. In Chapter 12 we consider the role of national assessment of all health interventions, including assessing the cost effectiveness of clinical prevention activities.

The importance of an increased focus on prevention and early intervention was a constant theme in submissions[29] and national consultations:

> *We are so busy with our fingers stuck in the dyke of 'treatment' that we cannot get around to what should be our real job – preventing the need for treatment.*[30]
>
> *Consumers advocate the value for individuals and for the health system of a significantly stronger focus on wellness and prevention …*[31]

There is a growing imperative to create and foster a health care system that highly values quality and safety. As a consequence, the concept of paying for performance has gathered momentum in other health systems (see Chapter 13). In Australian general practice, the Practice Incentives Program rewards practices for improvements in areas including information systems, after hours care, teaching, care plans, participation in National Prescribing Service quality use of medicines, care of diabetes, asthma, cervical screening or mental health, practice nurses, and rural location.

The following is suggested as a model for payment for performance for prevention and quality.

In addition to fee for service for doctors and supplementary grants to provide a broader range of services for people with chronic and complex care needs, primary health care practices may be

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[27] C Jackson and D O'Halloran (2008), Achieving a patient-centred, effective, efficient, robust and sustainable primary and community care sector 2020, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[28] Australian Institute of Health and Welfare (2008), Australian hospital statistics (Australian Institute of Health and Welfare: Canberra).

[29] For example, ACT Health (2008), Submission 5; National Seniors Australia (2008), Submission 127 to the National Health and Hospitals Reform Commission.

[30] Health professional (12 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Alice Springs.

[31] Consumers Health Forum of Australia (2008), Submission 509 to the National Health and Hospitals Reform Commission.

eligible in future for payments for performance in relation to illness prevention, chronic disease, avoidable complications, and other measures of quality:

- These payments could be based on improvements achieved rather than absolute levels of attainment, so that, for example, practices whose patients happen to have low rates of smoking or high rates of compliance with good chronic disease self-management would not automatically attract a payment, whereas practices whose patients have high rates of smoking which subsequently decline or low rates of chronic disease self-management that improve may attract a significant payment.
- The choice of illness prevention outcomes and interventions to be rewarded could be considered following assessment of the relative cost effectiveness of prevention interventions. We propose in Chapter 12 that a new 'umbrella' approach to health intervention assessment be developed across medical services, pharmaceutical services and clinical prevention.
- The chronic disease outcomes, avoidable complications, and other measures of quality to be rewarded could be based upon the advice of relevant bodies such as the Australian Commission for Safety and Quality in Health Care.

Reform direction 2.4

We support embedding a strong focus on quality and health outcomes across all primary health care services. This requires the development of good outcomes data for primary health care. We also want to see the development of performance payments for prevention and quality care.

2.4.5 Managing care of people with chronic and complex conditions through shared care arrangements

People with chronic and complex conditions will need support from an extensive range of health services. Based within the community are a group of vital medical specialists and specialty multidisciplinary teams providing care in the community – for example, in geriatrics, paediatrics, sexual health, and cancer/diabetes/renal teams. It is important that the care provided by these specialists for people with chronic and complex conditions is more effectively integrated into primary health care. We received a number of submissions that outlined innovations in fostering this partnership.

For example, one example of an innovative model of multidisciplinary care was described in General Practice Victoria's submission[32] regarding the Diabetes Cardiovascular Risk Management Program. In the case of people newly diagnosed with diabetes in Victoria's Dandenong Division of General Practice, patients are referred to a central coordination unit involving specialist care by their general practitioner.

Under this model, patients receive a comprehensive diabetes and cardiovascular assessment, develop a diabetes and cardiovascular management plan, and are referred to self-management education services and a multidisciplinary diabetes and cardiovascular clinic located at the hospital. The patient's general practitioner is linked to every point of service delivery, and the central coordination point facilitates the linkage of all required patient services to support the general practitioner in their role as coordinator.

Results of this program include 'high GP satisfaction, reduced emergency department presentations, reduced bed days by participants, improvements in HbA1C, HDL, an increase in the patient's ability to access appropriate support and a reduction of $1700 per participant hospitalisation cost.' [33]

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[32] General Practice Victoria (2008), Submission 84 to the National Health and Hospitals Reform Commission.

[33] General Practice Victoria (2008), Submission 84 to the National Health and Hospitals Reform Commission.

Similarly, another major group of people who are likely to need access to specialist services in the community are those with a long-term disability, including those with an intellectual disability. (We have indicated earlier that we need a broad definition of 'chronic and complex' when thinking about which people might benefit most from enrolment with a primary health care service.)

The National and NSW Councils for Intellectual Disability and Australian Association of Developmental Disability Medicine Inc[34] argued that:

> *It is very important that the existence and nature of an intellectual disability is diagnosed as early in childhood as possible and that the child's family then has access to specialised advice on health care issues that may be associated with the disability. Integration across the sectors, including multidisciplinary diagnostic and assessment teams, is very important for timely diagnosis and access to support services for child and family.*
>
> *Specialist children's health services, including paediatricians, are commonly accessed by children with intellectual disabilities and complex health needs. However, there is a major problem in transition to adult health care with there being very few adult doctors with specialised skills in working with people with intellectual disabilities and complex health needs. There needs to be a network of specialised intellectual disability health services to back up mainstream services across the lifespan.*

They go on to outline a model which we support that would be a key element of reformed and strengthened primary health care aimed at people with intellectual disabilities. This model includes:

- ensuring that all Comprehensive Primary Health Care Centres have a specific focus on people with intellectual disabilities with robust links to specialist multidisciplinary health teams who are skilled in the management of people with intellectual disabilities;
- ensuring ready access to diagnostic and prevention activities, and assessment services across all ages; and
- developing excellent systems that allow for effective transition from paediatric to adult care.

Reform direction 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.

2.4.6 Improving service coordination and population health planning priorities at the local level

Service coordination and population health planning priorities could be enhanced at the local level through regional structures

We believe that service coordination and population health planning priorities could be enhanced at the local level through regional structures. The advantages of this approach are highlighted in one of our invited papers by Jackson and O'Halloran as follows:

> *Real community participation in setting priorities for the local delivery of primary care is rare and could be better addressed within regional governance arrangements for health care … Regional governance structures which align Commonwealth and state, public and privately-funded services around integrated service delivery within a region are a top reform priority.*

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[34] National and NSW Councils for Intellectual Disability and Australian Association of Developmental Disability Medicine (2008), Submission 450 to the National Health and Hospitals Reform Commission.

> *This arrangement would also allow better management of diversity and complexity in local service delivery.*[35]

It is important that these regional structures have a critical mass of clients. It is envisaged that their size will vary across Australia, taking account of the fact that in remote and rural communities population sizes are usually insufficient to sustain traditional models of service provision.[36]

We believe the name of these new structures should reflect their core business, and suggest 'Divisions of Primary Health Care'. Rather than creating a new body, the divisions could be based on the existing Divisions of General Practice, taking into account alignment with other health region boundaries – for example, state and territory and Commonwealth programs such as those funded through OATSIH regions or natural regions in cross-border situations. Other factors to be considered could include their capacity to deliver on their core role and their ability to facilitate networks. Some of the tasks could be:

- Adopt a 'health stewardship' role for the health and wellbeing of the region.
- Complete primary and community health plans that identify current strengths and gaps within service provision.
- Develop a wellness and prevention profile of the region which outlines. numbers of people and families at risk with an emphasis on the life journey.
- Gather, analyse and report data and information on outcome indicators for national agreed public and preventive health targets, clinical indicators from local health providers, and consumer and community measures.
- Plan and advocate for local workforce needs.

Reform direction 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.

2.4.7 Improving access to care

Workforce reform was one of the most commonly raised issues in the national consultations:

> *We need primary health care practitioners ahead of anything else. Stop the body parts funding – the system is meant to look after people, not a kidney.*[37]

Using the primary health care workforce more efficiently and maximising multidisciplinary practice for the best care was a constant theme in consultations and submissions.[38]

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[35] C Jackson and D O'Halloran (2008), Achieving a patient-centred, effective, efficient, robust and sustainable primary and community care sector 2020, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[36] J Humphreys and J Wakerman (2008), Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[37] Health professional (3 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Darwin.

[38] For example, Parkinson's Australia (2008), Submission 143 to the National Health and Hospitals Reform Commission.

For example, the Royal College of Nursing[39] discussed expanding the scope of practice including access to MBS and PBS for nurse practitioners and stated:

> *Greater utilisation of the nurse practitioner role that delivers health care based on the nursing fundamentals of holistic, flexible, accessible, effective and equitable health care provision would be a sizeable move towards building a comprehensive health care system.*

We are not proposing that nurse practitioners or other health professional services be directly eligible for fee-for-service rebates under Medicare. Under current arrangements, simply adding additional professionals whose service would be eligible for rebates under Medicare would increase the total volume of services covered by Medicare and significantly increase total outlays, with the benefit and distribution of care in terms of improving health of the population unlikely to be commensurate with the increase in outlays.

In the reform direction outlined below (see also reform direction 14.2) we are arguing that increased access to the MBS and PBS, where doctors are scarce and under defined scopes of practice, should be available for registered non-medical practitioners. Supervision will be required in circumstances where work is performed by a competent health professional but billed to a specific medical practitioner. This supervision in some areas will be local but could be via videoconferencing or telehealth.

It is expected that use of information technology to provide primary health care services to people without the need to attend a practice or centre physically will be commonplace. This could include local primary health care services providing follow-up consultations (including by other health professionals) with a videoconference over the web, telephone contact, or by remote monitoring for people with chronic and complex conditions.

In some instances, these forms of care will need to be recognised for reimbursement, where they are best undertaken by professionals on a fee-for-service basis.

Reform direction 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

2.4.8 Providing primary health care services for Aboriginal and Torres Strait Islander peoples

In Chapter 8 we consider reforms to 'close the gap' and improve health outcomes for Aboriginal and Torres Strait Islander peoples. This includes the establishment of a National Aboriginal and Torres Strait Islander Health Authority.

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[39] Royal College of Nursing Australia (2008), Submission 164 to the National Health and Hospitals Reform Commission.

Reform direction 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.

Subject to consideration by the Authority of how it wishes to purchase or fund, it is anticipated that all of the approaches outlined in this section of the report for primary health care would also be available to and/or apply to health services specifically for Aboriginal and Torres Strait Islander peoples, such as community controlled health services. For example, Aboriginal and Torres Strait Islander peoples would be able to voluntarily enrol with a primary health care service (which may be a community controlled health service) if they have a young family or chronic and complex conditions.

2.4.9 Promoting personal control of health information

- There is an urgent need to develop a personal health record to support better care delivery for people, especially for those with chronic and complex care needs

We are of the view there is an urgent need to develop a personal health record to support better care delivery for people, especially for those with chronic and complex care needs. Despite the fact that a large number of general practitioners have become proficient in the use of electronic medical records, we have little connectivity across primary health care, hospitals and the patients. We commissioned a report on ehealth[40] which observed that:

> *The patient journey in the current system functions with disjointed communications and poor/inaccessible information causing duplication of services, a significant number of adverse events, and frustration for patients and their providers.*

As we have already noted, health care in Australia is delivered in a range of community- and hospital-based settings. In these settings, the sharing of information is limited and fragmented, or may not occur at all. There is the potential that poor information transfer due to the inefficiencies of outdated processes will undermine the delivery of care at each care interface for the patient.

A high dissatisfaction from patients, exasperation from clinicians, occurrence of adverse events and sub-optimal care scenarios can generally be attributed to the following factors:[41]

- failure to have sufficient and accurate patient information accessible at the point of care – rather, it is fragmented across different sites and clinical settings;
- poor sharing of information between healthcare providers, partly due to the lack of infrastructure (e.g. computer desktops, broadband connectivity, secure access, privacy regime) and poor ability to rapidly share information when it is required; and
- difficulty some patients have in remembering the complexity and breadth of their medical history and in explaining the various interactions they have had with health services.

Our invited paper on ehealth continues:

> *For example, the inability of a healthcare professional to discover what medications a patient takes, the sources of and reasons for medications being prescribed, and the confounder of numerous brands of the same drug can lead to confusion and adverse drug interactions. This is particularly a problem when patients go to more than one healthcare provider, have multiple medical conditions and medications, are stressed and are vulnerable. Preventable medication*

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[40] C Bartlett and K Boehncke, Booz & Company (2008), Ehealth: Enabler for Australia's Health Reform, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[41] C Bartlett and K Boehncke, Booz & Company (2008), Ehealth: Enabler for Australia's Health Reform, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

> *errors are very costly, with inappropriate use of medicines in Australia costing $380 million per year in the public hospital system alone.*[42]
>
> *The lack of high quality health information, and the ability to capture this and share it in a timely and useful format (i.e. content and media), has a particular impact on the treatment of chronic disease. Patients with chronic diseases often are complex and develop conditions that require referrals to a variety of medical and other specialist services. They frequently use multiple medicines and require care over extended periods of time from multiple providers.*[43]

We would argue that creating a robust and integrated primary health care service will require the finalisation and implementation of a person-controlled electronic personal health record.

An electronic health record for each Australian is one of the most important systemic opportunities to improve continuity, safety, reduce waste and errors and promote best care

The most important health information is a person's own health information. An electronic health record for each Australian is one of the most important systemic opportunities to improve continuity, safety, reduce waste and errors and promote best care. An electronic health record, which can be accessed by all health professionals and across all settings, with the person's agreement, is arguably the single most important enabler of truly person-centred care.

We will explore the prerequisites and incentives to allow us to reach this goal in our final report.

Reform direction 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.

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[42] Australian Institute of Health and Welfare (2002), Australia's Health No. 8 (Australian Institute of Health and Welfare: Canberra).

[43] C Bartlett and K Boehncke, Booz & Company (2008), Ehealth: Enabler for Australia's Health Reform, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

3. Nurturing a healthy start to life

Key messages

- The early years provide the foundation for a person's health and wellbeing in life.
- Improving the health and wellbeing of children is important both because of the intrinsic value and because doing so will improve the health of the population as young people age into adulthood.
- Investments in early childhood development are among the most powerful that a nation can make.
- The health of Australian children has improved over the past few decades, but there are concerning levels of childhood mental health and socio-behavioural issues, and increases in chronic and complex diseases, obesity and physical inactivity. Furthermore, the health of Aboriginal and Torres Strait Islander children is still significantly poorer than that of other children.
- The health of mothers antenatally and postnatally – and even before conception – can significantly impact on a child's health. A strategy that fosters a healthy start for children must include improving the health of their mothers.
- Tackling the root causes of many of the most prevalent children's health issues requires new ways of working across health, education, family support, and community development programs. We acknowledge the need for such a comprehensive approach. Within the scope of this report we focus on the health system, while recognising the importance of its links to other systems that are essential to securing a healthy start for children, particularly quality early childhood education and care, family support and community services.
- The early childhood health system has a number of shortcomings that limit its effectiveness, including significant inequities in access to services (particularly for children in rural and remote areas) and fragmentation of service delivery. The system is not responsive to children with complex needs from vulnerable families, and often fails children with a disability or developmental concerns, who have to navigate a complex system and often experience long waiting times and poor continuity of care.
- There is also variable access across Australia to specialist teams for children with chronic or severe health conditions.

Our reform directions

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.

3.1 Defining and scoping a healthy start

The evidence is clear: the early years provide the foundations for a person's health and wellbeing in life. This includes developing sound physical and mental health as well as the cognitive, social and emotional skills needed to succeed in life. As noted in the landmark study, *From Neurons to Neighbourhoods: the Science of Early Childhood Development*:

> *… virtually every aspect of early human development, from the brain's evolving circuitry to the child's capacity for empathy, is affected by the environments and experiences that are encountered in a cumulative fashion, beginning in the prenatal period and extending throughout the early childhood years.*[1]

With the multidimensional nature of health and wellbeing, nurturing a healthy start requires the involvement of a range of services and supports, including health and community services, and early childhood education and care. While acknowledging the relevance of this broader framework, the focus of this report is on the contribution of the health system to nurturing a healthy start to life.

■ The evidence is clear: the early years provide the foundations for a person's health and wellbeing in life

3.2 Building on our strengths

Australia is fortunate in having a universal health system that provides the foundation for a strategy for nurturing a healthy start to life. Health services are uniquely placed to influence children's outcomes in early childhood for several reasons:

- (Almost) all children have a contact with the health system at birth when initial health and parenting issues can be identified and addressed.
- Almost universally, the first contact that children have with the government service system is with health services.
- In addition, most women access health services in the antenatal period, providing a 'window of opportunity' to positively influence maternal health, nutrition and behaviour when women are most receptive.
- Health practitioners are generally welcomed by parents who see them as having a legitimate role and skills to provide support through pregnancy and child growth and development. This can be particularly valuable in providing assistance with parenting skills and behaviour and when working with vulnerable families.[2]
- Children and their families generally have regular contact with health services in the very early years, although access is poorer for disadvantaged families. This provides an ongoing opportunity to monitor and influence the child's health and development in the vital years before they reach the two other significant universal programs – early childhood education and care services, and schooling.

As emphasised by the Victorian Maternal and Child Health Special Interest Group:

> *MCHS [Maternal and Child Health Service] is at the forefront in providing health education messages that ultimately improve the health outcomes of those families through universal and early contact. The maternal and child health service has an uptake of 97 per cent of all families that are referred to them after the birth of their child. No other health profession has such immediate and ongoing contact with a public health focus and ideal opportunities for health prevention and promotion activities.*[3]

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[1] J Shonkoff and D Phillips (2000), From Neurons to Neighborhoods: The Science of Early Childhood Development (National Academy Press: Washington DC).

[2] D Olds, L Sadler and H Kitzman (2007), 'Programs for parents of infants and toddlers: recent evidence from randomised trials', Journal of Child Psychology and Psychiatry (48): 355–391.

[3] Victorian Maternal & Child Health Nurses Special Interest Group (2008), Submission 188 to the National Health and Hospitals Reform Commission.

Primary health services for children have traditionally been focused on developmental checks to identify problems, vaccinations and seeing sick children. While nurturing a healthy start must certainly include these activities, the evidence on the importance of early childhood argues for health services to be also involved in 'well' care that extends beyond physical health and includes the many dimensions of wellbeing.

3.3 Identifying the case for change

3.3.1 Valuing early childhood

> *The political approach will not change (including how spending is determined) unless we are able to change the discourse around children.*[4]

The importance of early childhood – including the antenatal period and the period from birth to eight years of age – is based on four key arguments.

First, childhood health and the uterine environment have a lasting impact on health and socio-economic status throughout life. Many adult health conditions – including major public health problems such as obesity, heart disease, diabetes and mental health problems – have their origins in childhood health conditions.[5]

Second, brain development in early childhood provides the foundation for lifelong wellbeing. Brain development is fastest and the brain most malleable during the first three years of life. Cognitive, emotional and social capabilities are all inextricably linked in brain development.[6]

Third, acting early has the best results. Early identification and intervention can prevent entirely or reduce the magnitude of many disabilities, developmental delays, behavioural problems and physical and mental health conditions.[7] For children at risk of poor outcomes, it is much more cost-effective to intervene in early childhood to prevent problems from developing and compounding than trying to 'fix' the problems later.[8]

Fourth, disadvantage begins early but can be ameliorated (at least in part) through quality antenatal and early childhood health, community and education services. For children without adequate stimulation, or who are exposed to unhealthy levels of stress in early childhood, disparities in learning and abilities appear within the first 18 months of life and generally persist into the school years and beyond.[9] The early childhood period provides a valuable opportunity to provide services that address factors of disadvantage before they are cemented in the next generation.

Investments in early childhood development are among the most powerful that a nation can make

Investments in early childhood development are among the most powerful that a nation can make. They enable more children to grow into healthy adults who can make a positive social and economic contribution to society and reduce the escalating chronic disease burdens in adults. They can also be a powerful force for equity, with interventions having the largest effects on the

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[4] Participant (5 August 2008), National Health and Hospitals Reform Commission special interest forum on early start to life in Sydney.

[5] N Halfon, H DuPlessis and M Inkelas (2007), 'Transforming the US child health system', Health Affairs 26 (2); and Early Child Development Knowledge Network of the Commission on Social Determinants of Health (2007), Early child development: a powerful equalizer, Final Report (World Health Organization: Geneva).

[6] Centre on the Developing Child at Harvard University (2007), A science-based framework for early childhood policy: using evidence to improve outcomes in learning, behaviour, and health for vulnerable children, at: http://www.developingchild.harvard.edu

[7] J Shonkoff and S Meisels (2000), Handbook of Early Childhood Intervention (Cambridge University Press: Cambridge).

[8] National Scientific Council on the Developing Child (2007), The Science of Early Childhood Development, at: http://www.developingchild.net

[9] National Scientific Council on the Developing Child (2007), The Science of Early Childhood Development, at: http://www.developingchild.net.

most disadvantaged children.[10] This was a strong message to the Commission from consultations and submissions:

> *The early years are the most critical time in terms of the largest gains to be made in the overall health and wellbeing of an individual. Those that are given the opportunity to grow and develop in a loving and nurturing environment will ultimately have the best intellectual, emotional and health outcomes.*[11]

3.3.2 Improving the health of Australian children

This section looks at key indicators of children's health (summarised in Figure 3.1).

In general, the health of Australian children has improved over the past few decades, but we lag behind other OECD countries in a number of important areas. Importantly, the health of Aboriginal and Torres Strait Islander children is significantly poorer than that of other Australian children. A recent assessment concluded:

> *While many of the key indicators of child health and wellbeing are improving, there are rising rates of childhood mental health and socio-behavioural issues, chronic complex diseases such as diabetes is on the increase, and childhood obesity and physical inactivity are increasing. There is no improvement in the rates of prematurity and low birth weight. Many experts now predict that this generation could have a lower life expectancy than their parents.*[12]

The health of young children is very dependent on the health, including mental health, of their parents, and particularly of their mothers. The health of mothers antenatally and postnatally – and even before conception – can significantly impact on a child's health. A strategy that fosters a healthy start for children must include improving the health of their mothers. Key considerations include:

■ A strategy that fosters a healthy start for children must include improving the health of their mothers

- While maternal deaths occur infrequently in Australia, maternal mortality rates for Aboriginal and Torres Strait Islander women are more than three times as high as for other women, and women living in rural and remote areas also experience higher rates of maternal death.[13]
- A significant minority of women report smoking during pregnancy and rates of alcohol consumption during pregnancy by Australian women are high. [14]
- Depression affects around 15 per cent of all women during the perinatal period, impacting on the health and wellbeing of mother and child.[15]
- While teenage fertility is falling, rates are substantially higher for Aboriginal and Torres Strait Islander women (five times higher) and for those living outside major cities.[16]

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[10] Commission on Social Determinants of Health (2008), Closing the gap in a generation: Health equity through action on the social determinants of health, Final Report (World Health Organization: Geneva).

[11] Victorian Maternal & Child Health Nurses Special Interest Group (2008), Submission 188 to the National Health and Hospitals Reform Commission.

[12] Australian Research Alliance for Children and Youth (2008), 'National health strategy must start with children', Submission to the Australian Government's Australia 2020 Summit.

[13] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare, Canberra).

[14] Department of Health and Ageing (2008), Improving maternity services: A discussion paper from the Australian Government, at www.health.gov.au

[15] Department of Health and Ageing (2008), Improving maternity services: A discussion paper from the Australian Government, at www.health.gov.au

[16] Australian Institute of Health and Welfare (2008), Making Progress: The health, development and wellbeing of Australia's children and young people (Australian Institute of Health and Welfare: Canberra).

Figure 3.1: Although the health of children and mothers is improving, there are still areas of concern

Areas of achievements	Areas of concern
Infant mortality rates have fallen	*Higher rate of low birth weight for Aboriginal and Torres Strait Islander infants, and infants living in rural and remote areas and socio-economically disadvantaged areas*
Gap in infant mortality rates for Aboriginal and Torres Strait Islander children is narrowing	*Low rates of breastfeeding, particularly among younger women and women living in socio-economically disadvantaged areas*
Immunisation coverage for 1 and 2 year olds is over 90 per cent	*Infant mortality, rates of low birth weight, Type 1 diabetes and teenage fertility compare unfavourably with other OECD countries, particularly for Aboriginal and Torres Strait Islander children*
Drop in asthma hospitalisation rate	*Increase in Type 1 diabetes and in hospitalisation rate, particularly for Aboriginal and Torres Strait Islander children*
Good dental health compared with other OECD countries	*Decline in dental health since the mid-1990s*
Fall in teenage fertility rate	*Dental health is worse for Aboriginal and Torres Strait Islander children and children living in rural and remote areas and socio-economically disadvantaged areas*
Decline in maternal mortality	*Children's level of physical activity*
	Obesity rates, which are higher for Aboriginal and Torres Strait Islander boys and children living in socio-economically disadvantaged areas
	Maternal mortality rates are higher for Aboriginal and Torres Strait Islander women and women living in rural and remote areas
	Smoking during pregnancy, which is particularly high for Aboriginal and Torres Strait Islander women and for young women
	High levels of alcohol consumption during pregnancy
	Antenatal and postnatal depression, which affect about 15 per cent of women

Source: Australian Institute of Health and Welfare (2008), Making progress: the health, development and wellbeing of Australia's children and young people (Australian Institute of Health and Welfare: Canberra) and Department of Health and Ageing (2008), Improving maternity services: A discussion paper from the Australian Government, at: www.health.gov.au

3.3.3 Improving child health services

While Australia is fortunate in having a universal health system as the foundation of child health services, there are a number of shortcomings of the current early childhood health system that limit its effectiveness.

First, there are significant inequities in access to services for families living in rural and remote areas, Aboriginal and Torres Strait Islander families, and disadvantaged families. These families access early childhood health services (including antenatal care) later and less frequently than the rest of the population but their children are often most at risk of developing poor outcomes.[17]

- The early childhood health system is fragmented

Second, the early childhood health system is fragmented. As with many aspects of the Australian health system, child and maternity health services are a combination of Commonwealth, state and territory government and privately funded and delivered services. They are provided in multiple settings by a range of different health professionals. The universal services that are most commonly accessed are maternity services provided in hospitals (including antenatal care), general practice, midwifery, and maternal and child health services provided in the community. In addition, many women access specialist obstetric maternity services. These services generally operate as separate systems and there is no automatic information sharing between systems. For example, a general practitioner may not be aware of the care provided to a patient by a maternal and child health service, which could result in the provision of different or conflicting advice and some families falling between the gaps.

Third, the current system is particularly failing families with children with special needs, including children with a disability or a developmental delay. These families have to navigate not only universal services, but also specialist and allied health care. They often experience long waiting times for specialist and allied health services, especially in rural areas, and poor continuity of care (see Figure 3.2).

Finally, while across Australia there are community child and family health services, there are important differences among the states and territories, which result in variable access and service provision for families.[18]

Figure 3.2: Childhood disease prevalence is increasing

The Australian Paediatric Society notes:

> *There is increased complexity of care for children expected in local settings. Children with cerebral palsy are undergoing new surgical techniques. Children with complex cardiac surgery are being returned to their communities earlier and require frequent follow-up. Children with diabetes, Crohns disease, allergy and coeliac disease are increasing in number and methods of therapy are becoming more complex. Children with complex developmental disabilities and needs are surviving into adulthood with few facilities or services available to support them. Behaviour disorders and school learning issues such as attention deficit hyperactivity disorder have increased in prevalence and are almost exclusively managed by paediatricians in rural areas.*

> *Currently in most rural settings with state government models it takes up to two years for assessment of a child suspected of having autism, up to six months to receive early intervention services for developmental disability and, in public hospitals, several years to have a regular general paediatric outpatient appointment. There is a demonstrable failure to maintain services for children in the Australian rural community.*

Source: Australian Paediatric Society (2008), Submission 479 to the National Health and Hospitals Reform Commission.

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[17] Department of Health and Ageing (2008), Improving maternity services: A discussion paper from the Australian Government, at: www.health.gov.au

[18] Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers' Advisory Council.

3.4 Creating a better future

Our life course approach to health seeks to promote the health and wellbeing of children, both because of the intrinsic value and because doing so will improve the health of the population as people age into adulthood.

Tackling the root causes of many of the most prevalent children's health issues requires new ways of working across health, education, family support, and community development programs

But creating a better health system to support a healthy start in life is complex because many of the key factors affecting children's health outcomes lie outside the health sector, including social, family, community, and economic influences which impact on children's development. As advocated by the Australian Research Alliance for Children and Youth, tackling the root causes of many of the most prevalent children's health issues requires new ways of working across health, education, family support, and community development programs (see Figure 3.3).

We acknowledge the need for such a comprehensive approach. Within the scope of this report, however, we focus on the health system, while recognising the importance of its links to other systems that are essential to securing a healthy start for children, particularly quality early childhood education and care, family support and community services.

Figure 3.3: A comprehensive approach to improving children's wellbeing is required

The Australian Research Alliance for Children and Youth is advancing collaboration and evidence-based action to improve the wellbeing of children and young people. This bio-psycho-social model, which acknowledges multiple interacting influences on the growing child, supports a multi-systems approach to:

- *ensuring healthy young families, by improving care during pregnancy and the postnatal period, promotion of health behaviours, early recognition of children at risk, and effective early intervention;*
- *securing early learning and care, by increasing access to quality early learning and care services, successful transitions to school and early identification and intervention of children at risk;*
- *supporting families and parents, by improving access to family support services, such as parenting education programs; assistance to achieve a better work/family balance; improved access to quality parenting information; and development of neighbourhood/social supports; and*
- *creating child-friendly communities, by fostering flexible and responsive services at the local level, creating better links and coordination among community services, reducing levels of family violence, community provision of children's activity, play and learning opportunities.*

Source: Australian Research Alliance for Children and Youth (2008), National health strategy must start with children, Submission to the Australian Government's Australia 2020 Summit.

3.4.1 Nurturing a healthy start to life

The case for change in Section 3.3 highlighted key areas for improvement in child and maternal health and in health services to nurture a healthy start in life. Addressing these areas would require a greater focus on health promotion and prevention, and better access to primary health care. Children with special needs would also require access to better coordinated primary health care, specialist care, allied health and other relevant services.

In this section, we outline a strategy for the health system for nurturing a healthy start to life for Australian children. We begin with an overview of the key concepts and then map the strategy in more detail.

Reform direction 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.

- The focus must be on partnering with parents

We have based our strategy on three key concepts. First, and most importantly, the focus must be on partnering with parents, supporting families – and the extended family – in enhancing children's health and wellbeing.

Second, it is based on a life course approach which identifies what is needed at different stages of life to secure a healthy start for children.[19] Our strategy for nurturing a healthy start to life begins at pre-conception, and covers the antenatal and early childhood periods.

Third, consistent with our principles, we emphasise a people- and family-centred approach, with a 'stepped care' approach to service provision, which shapes health services around the health needs of individuals, their families and communities. To do this, we emphasise 'progressive universalism'[20], with three levels of care to reflect different levels of need of children and families.

The first level is universal primary health care – the universal health services that address needs that all or most Australian children and families have to foster a healthy start in life. These services support families in enhancing their children's health and wellbeing, while picking up problems and addressing them early. As emphasised by Professor Bryanne Barnett, Foundation Chair of Infant, Child and Adolescent Psychiatry at the University of New South Wales:

> *Services must not be limited to high risk/needs groups only. Children in all socio-economic strata benefit from appropriate pregnancy and early childhood programs.*[21]

The second level is targeted care – health services designed for children or parents with identifiable risk factors, or children with early symptoms of disability or delayed developmental outcomes. The services would include paediatricians, allied health and family support, and would generally be provided upon referral from primary health care.

The third level is intensive care – services for children or parents in need of ongoing specialist attention for significant problems or vulnerabilities; for example, children with complex, chronic or severe health or developmental concerns. This level of care will often include a range of health and family support services. There would be a care coordinator attached to primary health care services to coordinate services for a child and their family in need of more intensive care.

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[19] N Halfon and M Hochstein (2002), 'Life course health development: An integrated framework for developing health policy and research', Milbank Quarterly 80(3): 433–79; and N Halfon, H DuPlessis and M Inkelas (2007), 'Transforming the US Child Health System', Health Affairs 26(2): 315–30.

[20] J Barlow and colleagues (2008), Health-led parenting interventions in pregnancy and early years, Research Report No. DCSF-RW070 (Department for Children, Schools and Family: London).

[21] B Barnett (2008), Submission 486 to the National Health and Hospitals Reform Commission.

Reform direction 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.

3.4.2 Mapping the strategy

The strategy for a healthy start draws on two of our identified building blocks: a life course approach to understanding health needs, and the three levels of care that respond to the needs of children and families.

Our strategy for the health system to nurture a healthy start to life begins with pre-conception, and then covers the antenatal period and early childhood stage, from birth up until eight years of age. For all stages, the level of universal care includes effective health promotion and prevention, and primary health care services which encourage good nutrition, healthy lifestyles and a high level of health literacy for all Australians, as we discuss in Chapters 1 and 2.

It is essential that health services connect well with other services which are important for the health and wellbeing of children ■

The health system would also be linked with two other universal service systems essential to nurturing a healthy start – early childhood education and care, and primary school. While we do not discuss their roles in any detail here, we recognise that there is a shared responsibility for nurturing a healthy start. It is essential that health services connect well with other services which are important for the health and wellbeing of children. For most children, after the very early years, health services 'pass the baton' to the early childhood education and care and school sectors to take the (non-family) lead in advancing a child's development and wellbeing.

Pre-conception stage

We begin our strategy for nurturing a healthy start with the pre-conception stage – the stage at which the health of Australia's future mothers and fathers is formed. At a Special Interest Forum on a Healthy Start held by the Commission, we heard about the importance of healthy lifestyles for young people, both for their own health and for the health of their children for those who become parents.

For example, smoking cessation programs – which should begin before pregnancy – have been found to be the most effective intervention in reducing the risk of low birth weight:

> *Preventing low birth weight will require a longitudinal and integrated strategy to promote optimal development of women's reproductive health, not only during pregnancy, but over the life course.*[22]

Furthermore, a partner's smoking status is a key determinant of a woman's smoking during pregnancy, highlighting the importance of health promotion for all young people.[23]

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22 J Barlow and colleagues (2008), Health-led parenting interventions in pregnancy and early years, Research Report No. DCSF-RW070 (Department for Children, Schools and Family: London).

23 J Barlow and colleagues (2008), Health-led parenting interventions in pregnancy and early years, Research Report No. DCSF-RW070 (Department for Children, Schools and Family: London).

Participants at the Special Interest Forum also raised particular concerns about alcohol consumption and the need for more responsible drinking among young people:

> *Alcohol consumption among young people is increasing dramatically in all states. Particular increases have been identified in rural and indigenous communities, with corresponding increases in the number of children being born with foetal alcohol syndrome. The level of hazardous drinking has escalated over the last 30 years, with an increase since 1996 from 12 to 20 per cent. This has resulted in a need to proactively respond to the particular needs of this population cohort as it moves through the system.*[24]

At the pre-conception stage, in addition to health promotion and prevention, and primary health care services, the universal services would include sexual and reproductive health services for young people. Targeted services would include ways to help teenage girls at risk of pregnancy – for example, through programs to encourage better connection with school.

Reform direction 3.3

We propose beginning the strategy for nurturing a healthy start to life at pre-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.

Antenatal stage

Universal primary health care services provide care for most women in the antenatal stage. Usually, women will have their pregnancy confirmed by a general practitioner or other primary health care worker, who can then link women to a midwife or obstetrician for management of the pregnancy and birth.

For women with special needs or at risk, there would be services provided through targeted care, such as home visits for very young, first-time mothers or women with substance abuse problems. As noted at the Special Interest Forum on a Healthy Start:

> *Pregnancy provides a good opportunity for mothers to make behavioural changes if they are given appropriate supports.*[25]

The Commonwealth Government is currently undertaking a separate review of maternity services, which covers antenatal services, childbirth, and postnatal services up to six weeks after birth.[26] The review is due to report on ways to improve maternity services in December 2008, and we will take account of its findings in our final report due in June 2009.

Reform direction 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.

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24 Participant (5 August 2008), National Health and Hospitals Reform Commission special interest forum on early start to life in Sydney.

25 Participant (5 August 2008), National Health and Hospitals Reform Commission special interest forum on early start to life in Sydney.

26 Department of Health and Ageing (2008), Improving maternity services: A discussion paper from the Australian Government, at: www.health.gov.au

Early childhood stage

As noted earlier, while across Australia there are community child and family health services which focus on the early years of life, there are important differences among the states and territories which result in variable access and service provision for families. These include:

- different schedules of contact visits across varied ages;
- different assessment and monitoring activities;
- varying emphasis across the domains of child physical health, child development, child social and emotional wellbeing, parental wellbeing and family functioning;
- different approaches to primary prevention strategies; and
- different approaches to interventions in response to identified issues.[27]

The universal child and family health services would provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring during early childhood

While allowing for local responsiveness, under our strategy for nurturing a healthy start to life the universal child and family health services would provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring during early childhood.[28] The schedule would cover the period from between birth to eight years of age, reflecting the critical early childhood period, and seeing children through the important transition to primary school. The schedule could be provided by a range of health professionals, including general practitioners, child and family health services, and school nurses.

An evidence-based schedule of contacts would be designed that allows for the delivery of core services to children and families at age-appropriate times. A list of the core services and activities to be provided under the schedule of contacts is at Figure 3.4.

Figure 3.4: The following are core services for children and families to be provided by child and family health services from birth to eight years of age

Core services	Activities
Monitoring of child health, development and wellbeing	*Health monitoring, including physical health and growth* *Monitoring of child development, which is particularly important for the early identification of children with developmental delay, and provision of/referral to early intervention services* *Monitoring of a child's socio-emotional wellbeing and parent–child attachment*
Early identification of family risk and need	*Comprehensive assessment of risk and protective factors for a child's development, including parent, child, family and community factors* *Maternal health (including mental health) screening* *Identification of family support needs across multiple domains (for example, health and housing)* *Identification of risk of child abuse and neglect*

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[27] Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers' Advisory Council.

[28] This section draws on a recent review of best practice universal family and child health services undertaken to develop a draft national framework for child and family health services for the Australian Health Ministers' Advisory Council. The (draft) National Framework for Universal Child and Family Health Services sets out the core universal services that all Australian children and families should receive, regardless of where they live, and how and where they access their health care. Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers' Advisory Council.

Figure 3.4: The following are core services for children and families to be provided by child and family health services from birth to eight years of age

Core services	Activities
Responding to identified needs	*Advice and assistance* *Practice-based interventions (for example, sleep intervention or smoking cessation)* *Referral to targeted or specialist service (for example, speech pathologist or intensive family support)*
Health promotion and prevention	*Health promotion education – core topics are support for breastfeeding, sudden infant death syndrome prevention and education, injury prevention, promoting early literacy and oral health education* *Immunisation*
Support for parenting	*Anticipatory guidance – practical information about 'what to expect' in the child's behaviour, growth and development in the upcoming age period* *Promoting positive parenting, including engaging fathers* *Peer support programs which build parental confidence and capacity and provide a social network of support.*

Source: Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers' Advisory Council.

Under the schedule, contacts would align with critical periods for identifying and responding early to issues. Figure 3.5 illustrates the sensitive periods for early development. There would also be regular enough contact to develop a relationship between the family and the service. A relationship based on trust is essential for the effective identification of needs and risks in a family. Regular contact also enhances participation in the service and ensures the family remains engaged for critical monitoring points.[29]

There is also strong evidence supporting the importance of the very early years (as shown in Figure 3.5), and contacts would be weighted towards the first three years of life. Where possible, the initial contact by the service would be universally offered as a home visit within the first two weeks following the birth. A home visit has two benefits: it is convenient for new parents so it engages those who may otherwise be 'hard to reach', and it provides an opportunity for the home visitor to observe the home environment and provide advice to parents tailored to their individual needs.[30]

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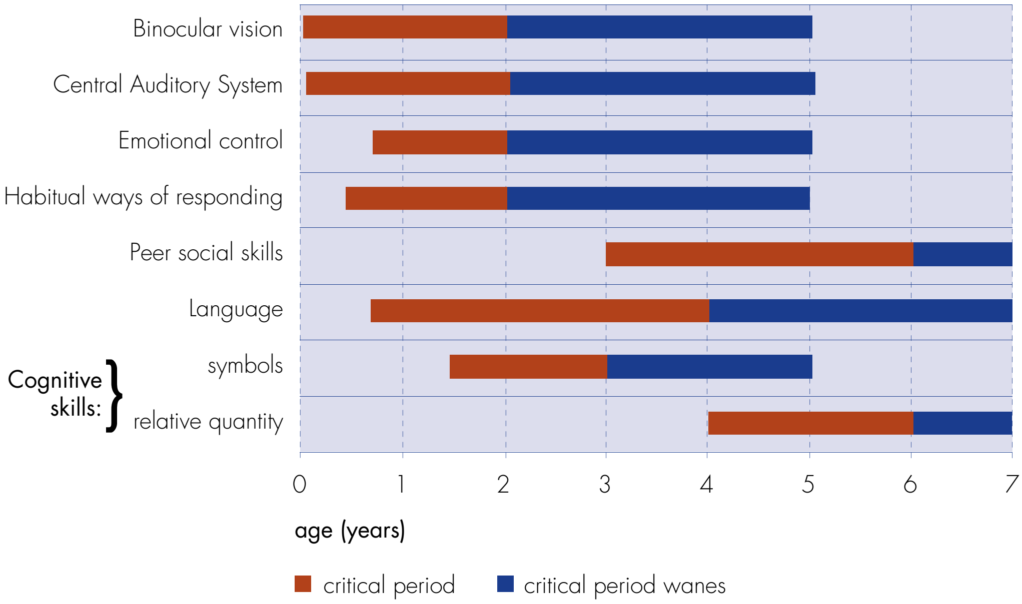
[29] Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers' Advisory Council.

[30] Allen Consulting Group (2008), A (draft) national framework for universal child and family health services, Draft Report to the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee of the Australian Health Ministers' Advisory Council.

Figure 3.5: There are sensitive periods for early childhood development



Source: M McCain and J Mustard (1999), Early Years Study Final Report: Reversing the Real Brain Drain (Publications Ontario: Toronto)

Reform direction 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.

There is strong evidence of the effectiveness of sustained home visits for new mothers with additional risk factors

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 an appropriate pathway for targeted care, which could be based on an enhanced schedule of contacts for the child, including ongoing home visits. There is strong evidence of the effectiveness of sustained home visits for new mothers with additional risk factors, such as very young age and unmarried. Evidence shows that participants had healthier lifestyles and children visited had fewer health problems.[31] Programs are more effective when they last six months or more, involve more than 12 home visits, and begin early (either antenatally or at birth).[32]

In many cases, the pathway will be a referral to a targeted or specialist service for children with a disability or developmental delay and children or mothers with significant risk factors (such as children in out-of-home care or mothers with symptoms of depression or anxiety). For example, this could include paediatricians, speech pathologists and mental health services (mental health services are discussed in Chapter 10). We noted earlier, however, that many families had problems accessing specialist and allied health services for children with a disability or a developmental delay, particularly in rural areas. We have identified in Chapter 2 the importance of voluntary

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[31] D Olds and colleagues (2007), 'Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial', Pediatrics 120 (4): e832–e845; D Scott (2006), 'Family home visiting: a way forward', Presentation at Second National Parenting Conference Adelaide, at: http://www.unisa.edu.au/childprotection

[32] J Barlow and colleagues (2008), Health-led parenting interventions in pregnancy and early years, Research Report No. DCSF-RW070 (Department for Children, Schools and Family: London).

enrolment with primary care health service for such families to promote improved coordination of care and to reduce the chance that such families will fall through the 'health service gaps'. In addition, we have proposed that there needs to be strengthening of shared care arrangements so that there is better access to specialist, multidisciplinary teams providing care in the community and integration of this care with primary care. Finally, there is also a need to enhance training of health professionals so they can better support the needs of such families.

Reform direction 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.

Some children will require more intensive care, particularly children with chronic or severe health or developmental concerns. Where a child requires more intensive care, a care coordinator attached to primary health care services would be available to coordinate the range of services these families often need. This proposal responds to the views of many people in submissions and national consultations of the need for early intervention for children with a disability or developmental delay. As one participant put it:

> *… one of our priority areas was early intervention, but in considering early intervention from a health perspective rather than an education system. Focussing on early identification of children with special needs and then helping them to get access to a range of services including allied health. Someone talked about the concept of trying to reduce the lottery, so trying to come up with a better strategy so that families hear about what's available and they are able to get access to those services without having to jump through hoops and, you know, coming up against lots of closed doors.* [33]

■ Some children will require more intensive care, particularly children with chronic or severe health or developmental concerns

Reform direction 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.

The beginning of compulsory schooling at age four to five provides the opportunity for a comprehensive health and development check for all children, as provided for by the Commonwealth Government in the 2008–09 Budget. Health or developmental concerns identified at this time would be relayed to the school nurse if appropriate for follow-up action or continued monitoring.

School nurses are an important resource for promoting and monitoring children's health, development and wellbeing, particularly through the important transition to primary school. We support all primary schools having access to a school nurse. This could be done in number of ways. For example, Victoria has a Primary School Nursing Program under which all public schools are visited by nurses. The program provides:

- a health assessment to enable early identification of health problems;
- advice, information and referral to other services;
- health promotion aimed at maintaining and improving the health and wellbeing of children and their families; and

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33 Health professional (9 July), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Adelaide.

- support to families and school communities by providing information and education on issues relating to school-aged children.[34]

Reform direction 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.

3.4.3 Making it happen

It is essential that child and family health services are linked to primary health care services

Ensuring a healthy start to life must be embedded in primary health care. Mostly, the universal schedule of contacts from birth to eight years of age will be provided by child and family health services (although it could be provided by general practitioners and the activities in later childhood could be provided by school nurses). Child and family health services will be incorporated in the Comprehensive Primary Health Care Centres we have proposed in Chapter 2. It is essential that child and family services are linked to primary health care services to ensure continuity of care and a full understanding of a child's health care needs. This would be particularly important for targeted and more intensive care for which referrals would often come from a general practitioner.

As argued in a submission from the Victorian Maternal & Child Health Special Interest Group:

> *There needs to be greater consistency of information between maternity services and universal primary health services around the information provided to, and care for new families.*[35]

Ideally, families would be enrolled with a primary health care service (as proposed in Chapter 2) as this would enable well integrated and coordinated care and a comprehensive understanding of the health needs of a child and their family. This would be the foundation for a strong partnership throughout life between a person and primary health care.

Reform direction 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.

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[34] Department of Human Services (2008), The Primary School Nursing Program, at: http://www.dhs.vic.gov.au/phkb

[35] Victorian Maternal & Child Health Nurses Special Interest Group (2008), Submission 188 to the National Health and Hospitals Reform Commission.

4. Ensuring timely access and safe care in hospitals

Key messages

- By international standards, Australia's public and private hospitals provide high quality care for most people most of the time.
- Our hospitals perform many vital roles. They are an essential part of the 'care continuum' of services. They are one of the major settings for continuing education of the present and future generations of health care professionals. They undertake world-class research that is used to provide better health care treatment and improve outcomes for people.
- We also know that our hospitals are under severe pressure, directly influencing their ability to provide safe, high quality, accessible and timely care to all patients.
  – Waiting times for planned or 'elective' surgery (such as hip replacements) and critical medical care (such as radiotherapy) are too long for many people who rely on public hospitals.
  – Public hospital emergency departments are often over-crowded (potentially compromising safety with adverse outcomes including preventable deaths) and 30 per cent of people visiting an emergency department are not seen within what is regarded as clinically safe times.
  – A significant minority of patients experience problems with the quality or safety of the care provided by public and private hospitals.
- Improvements in other parts of the care continuum of the health system (strengthening primary health care, expanding community-based mental health services, creating a network of sub-acute services and providing better choices and access for older people needing aged care services) are all vital to providing the right care in the right time and the right place for people and simultaneously reducing some of the pressure on hospitals.
- Our hospitals are a precious resource but not unlimited and we should ensure that they are used wisely.
- Looking to the future, there are opportunities to reshape the role of hospitals and improve the delivery of care for people and their families. We lack a systemic approach to embedding innovation and best practice more rapidly in every Australian hospital.
- There is also scope to improve the way in which we integrate and get best use of our mixed system of public and private hospitals.

Our reform directions

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.

For the purpose of this interim report, we focus particularly on those issues with regard to hospital care that have gained most public attention, in particular timely access to care and safety. We also discuss aspects of the wider health system that affect use of hospitals and hospital performance, many of which are dealt with in more detail in other chapters. We will develop these themes more fully in our final report.

4.1 Defining and scoping hospital care

Hospitals provide the most complex and costly care to the sickest people in our community. They are also where most babies are born, and where many people die. They are the source of emergency care when people are suddenly and/or severely ill, and when no other care is available it is often to hospitals that people turn.

It is crucial that we make the best and most efficient use of these vital and expensive services.

Approximately 40 per cent of all health expenditure in Australia in 2006–07, or about $34 billion, was on hospital care. Hospital services represent about 3.5 per cent of Australia's gross domestic product (GDP) and expenditure on hospitals is projected to be the fastest growing element of health expenditure over the next two and a half decades.[1]

In 2006–07 Australia had 1282 public acute and private hospitals – 739 public acute hospitals, and 543 private hospitals. These hospitals range from small country and 'bush nursing' hospitals through to major metropolitan referral hospitals and specialist women's and children's hospitals. Half (265) of the private hospitals were free-standing day hospitals. In 2006–07 there were 53,565 beds in public acute hospitals, and a further 26,758 in private hospitals including 1992 in the private free-standing day hospitals. Over the last ten years the number of patient days in public acute hospitals increased by 10.2 per cent while, in private hospitals, patient days increased by 24.9 per cent.[2]

In 2006–07 public and private hospitals provided 7.6 million episodes of care for people admitted to hospital, 39.9 million outpatient occasions of service and a further 6.7 million emergency department occasions of service. Over time, Australian public hospitals have experienced sustained growth in outpatient attendances and all hospitals have seen a reduction in the average time that a patient stays in hospital (from 4.1 days in 1997–98 to 3.3 days in 2006–07). Increased provision of same day procedures, investigations and treatments and alternative care models such as hospital-in-the-home have contributed to this average reduction in length of stay. Like other countries in the Western world, hospital admissions have continued to increase since the early 1990s. In the five years to 2006–07 acute hospital separations increased by an average rate of 3.4 per cent each year.[3]

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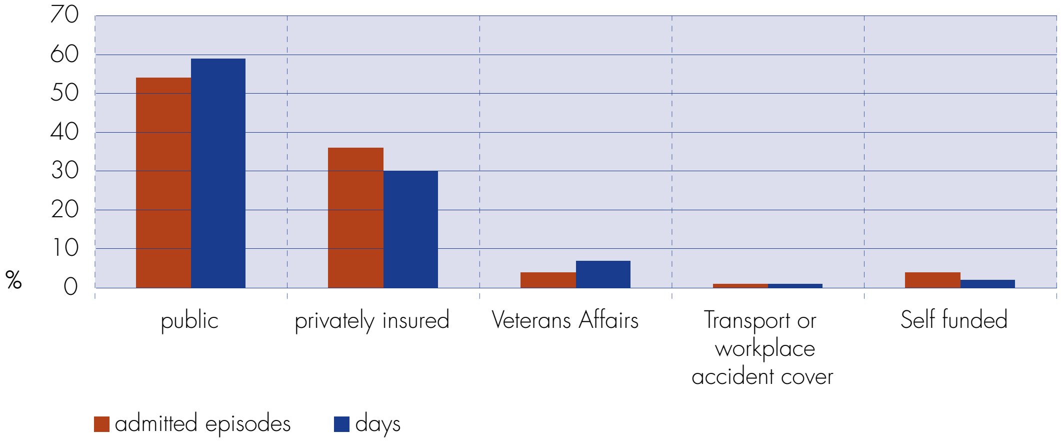
[1] J Goss (2008), Projection of Australian health care expenditure by disease, 2003 to 2033, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[2] Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

[3] Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

Figure 4.1 shows the proportion of patients and days in hospitals by the source of payment for their care.

Figure 4.1: Most episodes in hospitals are for public patients, followed by the privately insured, then veterans and their families



Source: Australian Institute of Health and Welfare (2008), Australian Hospitals Statistics 2006–07

The full-time equivalent workforce in public hospitals is around a quarter of a million.[4] There are another 47,000 full time equivalent employees working in private hospitals.[5]

In addition to health care, hospitals also play vital roles in clinical education, training and research.

4.2 Building on our strengths

Australia's hospitals provide virtually all of the proven treatments available anywhere else in the world. These range from the most expensive and complex, such as heart, lung or liver transplants, to the relatively simple but essential, such as removal of an inflamed appendix.

Australians also have access to the most complex technologies for diagnosis and treatment though our hospitals, such as Positron Emission Tomography for medical imaging, and linear accelerators for cancer treatment.

Australians are indeed fortunate to have access to such a wide variety of treatments provided by highly competent people, most often at no direct charge to the person treated.

A great strength of our health system is that all Australians eligible to receive a Medicare card can receive public hospital care at no out-of-pocket cost to themselves. Those with private insurance and those entitled to other forms of third party payment such as veterans and people who have suffered workplace or transport accidents can choose to have treatment as a private patient in a public or a private hospital, and by the doctors of their choice. Others, who have the capacity to pay for themselves, also have this choice.

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[4] Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

[5] Australian Bureau of Statistics (2008), Private Health Establishments 2006–07 (Australian Bureau of Statistics: Canberra).

People are often at their most vulnerable when they go to hospital. They may be very unwell, in severe pain or at risk of dying. Many are incapacitated, and many are frail. Most are away from their families and may be completely unprepared for their hospital stay and the disruption it causes to their daily lives. Essential to even the most complex care in hospitals is personal interaction with trusted and compassionate carers. People working in our hospitals include many of the most highly trained professionals in our community.

There is much of great value in our hospital system, but there is also room for improvement.

■ There is much of great value in our hospital system, but there is also room for improvement

4.3 Identifying the case for change

The underlying issues affecting the capacity of hospitals to provide timely and safe care are multi-dimensional but can be best understood in two groupings:

- aspects of hospital care or performance which are significantly within-hospital issues such as the capacity to balance emergency department and planned procedure performance, the provision of outpatient care, teaching, research, safety and quality; and
- other elements of health care which affect hospital performance. Many of these are the subject of other chapters in this report, and so the discussion of them here is brief but serves to highlight the opportunities for parallel reform in areas possibly outside hospitals' direct sphere of influence. These include sub-acute care, aged care, community-based care and primary health care services.

4.3.1 Access to care in hospital emergency departments

Across all categories of urgency, only 70 per cent of people presenting to public hospital emergency departments are seen within clinically appropriate times. Worryingly, more than a third of urgent patients are not seen within clinically appropriate times (see Figure 4.2).

Figure 4.2: Many people are not seen as quickly as they should be in emergency departments

Triage (urgency) category	Description	Patients in category (per cent)	Patients seen in benchmark time (per cent)	Patients admitted (per cent)
1	*Resuscitation*	*1*	*99*	*79*
2	*Emergency*	*8*	*78*	*62*
3	*Urgent*	*32*	*65*	*42*
4	*Semi-urgent*	*47*	*66*	*16*
5	*Non-urgent*	*12*	*88*	*5*

Source: Australian Institute of Health and Welfare, Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

The most critical issue for the performance of emergency departments in major public hospitals is 'overcrowding'. Overcrowding refers to the situation where there are more people in an emergency department receiving treatment (not waiting for care) than can properly be looked after by the available staff. Overcrowding should not be confused with people who present needing only low urgency care (discussed further below). People with less urgent needs for care can (and generally do) wait for treatment.

Emergency departments are meant to assess people's need for care and stabilise their condition; determine and provide any immediate treatment required; and then send them on to the most appropriate place to meet any ongoing care needs. This may be at home with assistance from their GP, provided by another health service or admission to hospital for further investigation or treatment. Overcrowding is directly related to a hospital's capacity to admit quickly those people who have been assessed and stabilised in the emergency department and who need admission to a hospital bed for ongoing care. Both mathematical modelling of patient flows[6], and empirical study[7] have found that, in hospitals operating at an inpatient occupancy of 85 per cent or more on any given day[8], some people requiring admission from the emergency department will end up unable to be promptly admitted. This is known as 'access block'.

> *The single most important barrier to the provision of quality care in emergency departments is access block.*[9]

Inability to admit people promptly to hospital from the emergency department results in a situation where there are more patients in the emergency department than can be properly cared for

Inability to admit people promptly to hospital from the emergency department results in a situation where there are more patients in the emergency department than can be properly cared for. This is associated with increased stress on emergency department staff, and sometimes a need to divert ambulances bringing new patients to other hospitals. As we heard from one paramedic:

> *One of the big issues … is the frustration of trying to get patients moved through hospitals.*
>
> *… the system seems to go into a wind-down for weekends where we've got greatest potential of … discharging people and actually moving them out of the hospitals but it seems that Monday to Friday the hospitals work on office hours and, if we could start moving that in conjunction with better facilities in emergency departments and the general practitioner clinics within our emergency departments, we could start to see a better of movement of patients together with proper care and movement throughout the system.*[10]

Major metropolitan public hospitals in Australia commonly experience days when they operate at capacity with high levels of occupancy, occasionally exceeding 100 per cent. This means that more people have been admitted for care than there are available beds – usually achieved by having people on trolleys in the corridors of the hospital.

Occupancy rates in hospitals are a complex function of the numbers of people presenting who require admission – both planned and unplanned – which vary according to the time of the year, the day of the week, and the time of the day as well as to the prevalence of illnesses in the community, and the numbers of people leaving hospital – this also varies by time of day, day of the week, and the availability of follow-up care for those requiring it.

An Australian study has found an association between emergency department overcrowding and increased deaths of people admitted after attending the emergency department.[11] Other authors have also demonstrated a strong association between access block/overcrowding and increased mortality.[12]

We do not see a role for the Commission in prescribing specific bed management practices within hospitals. Other reports, both in Australia and overseas, have investigated bed management and documented strategies to improve bed availability. Very recent examples in Australia

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[6] A Bagust, M Place and J Posnett (1999), 'Dynamics of bed use in accommodating emergency admissions: stochastic simulation model', British Medical Journal (319): 155–158.

[7] A Forster, I Stiell, G Wells and colleagues (2003), 'The effect of hospital occupancy on emergency department length of stay and patient disposition', Academic Emergency Medicine 10 (2): 127–133.

[8] Calculated as the number of patients in the hospital at midnight plus the number of other patients who occupied an inpatient bed for any portion of the preceding 24 hours.

[9] Australasian College of Emergency Medicine (2008), Submission 19 to the National Health and Hospitals Reform Commission.

[10] Paramedic (4 June 2008), National Health and Hospitals Reform Commission consultation with frontline health professionals in Sydney.

[11] P Sprivulis, J Da Silva, I Jacobs and colleagues (2006), 'The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments', Medical Journal of Australia 184 (5): 208–212.

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

include a report by the Victorian Auditor General, Managing Acute Patient Flows, published in December 2008[13], and the Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals.[14] And indeed these challenges are by no means unique to Australian hospitals.[15]

However, we do recognise the need to fund, resource and support through appropriate policies and measurement strategies a sufficient 'base' bed capacity to enable efficient patient flow through emergency departments. As part of addressing this, planning of admitted patient capacity for public hospitals that provide 24-hour 7-day-a-week emergency department care should be based on a target maximum daily occupancy of 85 per cent. In our view there is a need to encourage adoption of proven patient flow-management practices by providing marginal payment incentives for the outcomes of good bed management rather than prescribing particular strategies. These should include incentives for hospitals to ensure that people treated in emergency departments who require admission can be admitted promptly.

4.3.2 Low urgency presentations to hospital emergency departments

It has been argued that the number of semi-urgent and non-urgent presentations to emergency departments is an indication of the failure of general practice to meet the needs of these people, and also that dealing with low urgency patients is a cause of poor performance of hospital emergency departments.[16]

> *The system at the moment forces people to go to emergency departments. If I can't see my GP I go straight to the emergency department.*[17]

On the other hand, it must be noted that almost one in six people categorised as semi-urgent end up being admitted to hospital, as do one in twenty of those in the non-urgent category. Furthermore, a number of people categorised as low urgency have already seen a GP and been referred to hospital for treatment the GP cannot provide. This suggests that not all low urgency presentations to hospital emergency departments could be adequately looked after by a GP.

Perhaps the principal disadvantage of people attending emergency departments for low urgency care is that it fragments their care and ongoing management. Hospitals may provide excellent care while a person is in the emergency department, but they are generally not set up to provide systematic follow-up care or to gain a comprehensive understanding of a person's health and wellbeing over several encounters (although in some cases they may end up doing so).

For reasons of quality of care over time, we believe it would be better for most people presenting to emergency departments who do not require urgent care to obtain their care from a primary health care service with which they have a continuing relationship. In this way the doctors and other health professionals in the service develop a familiarity with the person's health and circumstances, enabling them to provide better treatment and care over time.

> *I'm an Emergency Nurse and I think its very important that we educate the public on the role of the emergency department, what it is there for, what is appropriate and what other services are available as opposed to the emergency department.*[18]

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[13] Victorian Auditor-General (2008), Managing acute patient flows, at: http://download.audit.vic.gov.au/files/Patient_Flow_Report.pdf

[14] P Garling (2008), Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, at: http://www.lawlink.nsw.gov.au/acsinquiry

[15] See, for example: D DeLia (2007), Hospital capacity, patient flow, and emergency department use in New Jersey, A Report to the New Jersey Department of Health and Senior Services (The Institute for Health, Health Care Policy and Aging Research, Rutgers University: New Jersey).

[16] Booz Allen Hamilton (2007), Key drivers of demand in the emergency department: a hypothesis driven approach to analyse demand and supply (New South Wales Health: Sydney).

[17] Consumer (19 June 2008), National Health and Hospitals Reform Commission consultation meeting with community in Brisbane.

[18] Nurse (17 June 2008), National Health and Hospitals Reform Commission consultation with frontline health professionals in Cairns.

People go to emergency departments as the best available choice from their point of view

- One of the critical challenges to achieving this is that people go to emergency departments as the best available choice from their point of view.

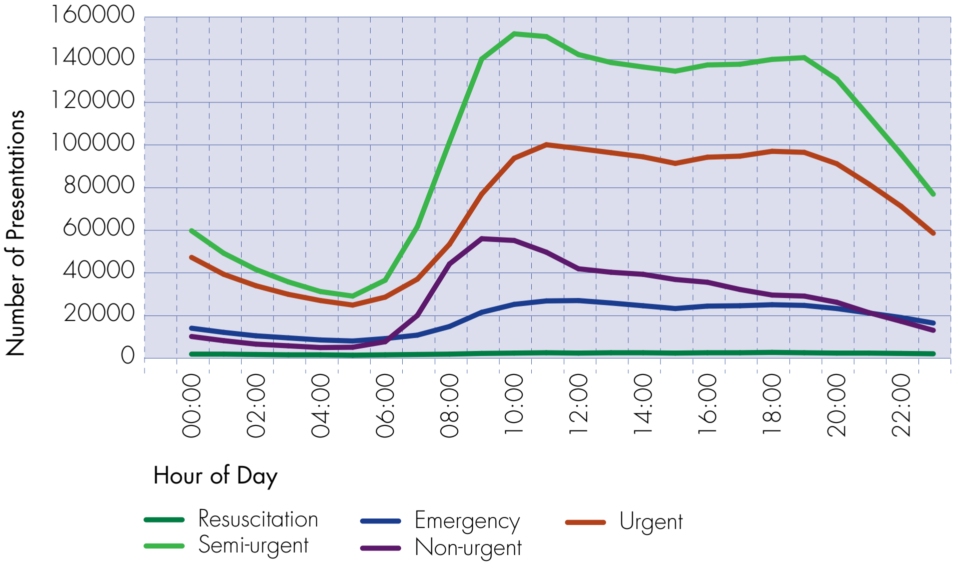
> *Despite differences in the presentation rates, patients in all demographic groups [attending an emergency department for low urgency care] were most likely to identify self-assessed urgency; being able to see the doctor and having diagnostics done in the same place; and self-assessed seriousness or complexity as the reasons for presentation.*[19]

This is partly driven by lack of availability of same-day appointments and extended hours at many general practices, and also the fact that general practices do not provide in one place all the services a person may need. A person attending a GP who requires pathology tests or medical imaging generally has to make additional appointments and/or attend a pathology collection service and/or diagnostic imaging clinic. They generally also require a subsequent follow-up consultation with the GP. Altogether it can take several trips and sometimes several days from initial presentation to final outcome. While waiting times for treatment for low urgency patients in emergency departments can be long, people are reasonably assured of an outcome that day.

We believe the remedy to this is to develop larger, more comprehensive, primary health care services which are able to offer convenient same-day access to 'one stop' care for people who might otherwise present to a hospital emergency department. This requires centres that include not only GPs and other primary health care professionals, but also ready access, preferably on-site or adjacent, to diagnostic services. These centres should be open for extended hours; for example, from 6.00 am to 10.00 pm – the hours during which most low urgency presentations to hospital emergency departments take place (see Figure 4.3).

The development of Comprehensive Primary Health Care Centres is a key focus of Chapter 2 of this report.

Figure 4.3: Most people present to emergency departments during 'daylight' or 'twilight' hours – from 6.00am to 10.00pm



Source: Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

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[19] P Siminski, A Bezzina, L Lago and K Eagar (2008), 'Primary care presentations at emergency departments: rates and reasons by age and sex', Australian Health Review 32(4).

Some people presenting to GPs actually require hospital care quickly. It is a source of frustration to many GPs that hospital staff cannot preferentially triage people whom GPs refer to a hospital emergency department for good reason. A proportion of people presenting to our proposed Comprehensive Primary Health Care Centres will also be identified as needing hospital care. In order to ensure that such people receive attention within a clinically appropriate time, rather than having to wait twice, hospitals and Comprehensive Primary Health Care Centres should have agreed referral and transfer protocols.

> *I have been here for 39.5 years and one of the best innovations we've had apart from the mobile phone is the patient flow unit which is based at Dubbo Hospital. If we wish to transfer mental patients or psychiatric patients or medical patients we ring through patient flow, they put us onto the admitting officer and then they arrange the transport of the patient in the most appropriate way and this has worked out very well.* [20]

Further work is required to understand the relative cost benefit of treatment in primary health care settings as compared to low urgency attendances at hospital emergency departments. This information will help planning processes to ensure that the 'best' care is provided to low urgency patients and that hospital resources are used wisely and resourcefully.

4.3.3 Access to 'elective' admission

> *Medicare and the public hospital/health system are no longer effective in providing accessible services to all Australians – barriers of co-payments, workforce shortages and waiting lists result in inequitable access, contributing further to unequal outcomes.*[21]

Another challenge for public hospitals is delays in scheduling and repeated cancellations for 'elective' procedures. This aspect of 'timely access to care' receives the greatest public attention. In this context 'elective' means procedures and treatment that in the view of the treating clinician are necessary and for which admission can be delayed for at least 24 hours. The term elective has connotations that the procedures or treatments are optional or a matter of choice. However, most elective procedures are essential; for example, cataract surgery to remedy going blind, and joint replacements to remedy chronic pain and maintain mobility. In some instances 'elective' procedures can be critical to a person's survival; for example, diagnostic procedures to confirm whether someone has cancer.

- Most elective procedures are essential; for example, cataract surgery to remedy going blind, and joint replacements to remedy chronic pain and maintain mobility

During our consultations we heard that there is wide variation across Australia in the time that people who have been deemed 'ready for care' wait before they are scheduled for surgery in a public hospital. Once scheduled, bookings might be cancelled, even multiple times, because of the precedence given to emergency patients. Lack of prompt access to planned procedures is undoubtedly resulting in a significant burden of disability and pain, and may prejudice people's access to prompt diagnosis of cancer, with possible life threatening effects. Similarly, delays in access to radiotherapy may impact on the potential outcome of cancer treatment.

Notwithstanding the levels of growth in public hospital activity and expenditure in recent years, waiting times for elective treatment were longer in 2006–07 than they were in three of the preceding four years.[22]

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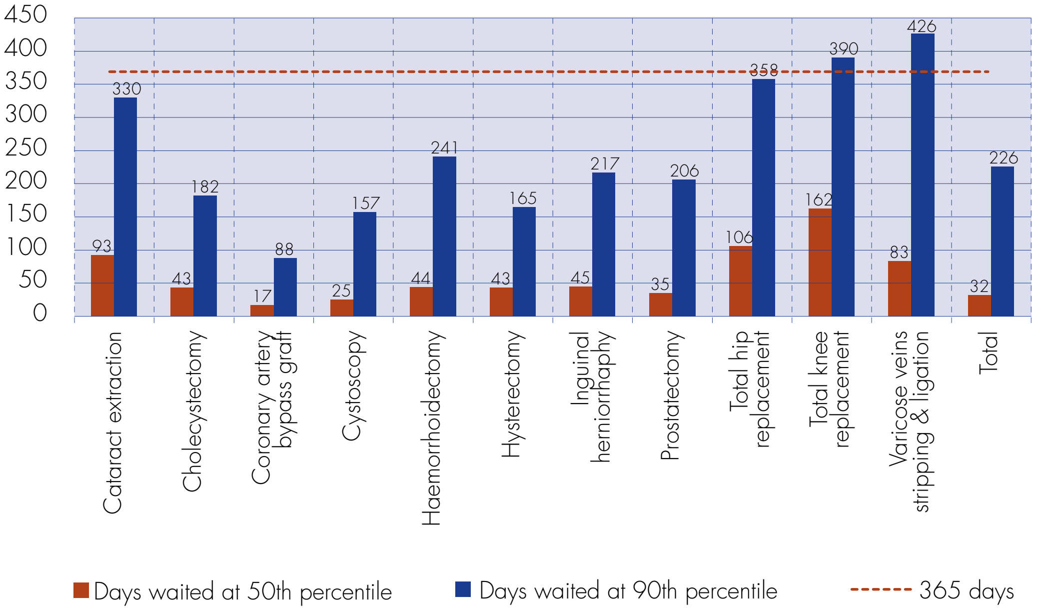
20 General practitioner (3 June 2008), National Health and Hospitals Reform Commission consultation with frontline health professionals in Dubbo.

21 Victorian Primary and Community Health Network (2008), Submission 189 to the National Health and Hospitals Reform Commission.

22 Australian Institute of Health and Welfare (2008), Australian Hospitals Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

Figure 4.4 shows the median waiting time at the 50th and 90th percentiles by type of procedure for a selected basket of procedures. Median waiting time (or the 50th percentile) means that half of all people wait longer than that number of days. Similarly, waiting time at the 90th percentile means that ten per cent of all people wait longer than that number of days. As can be seen from the figure, there are people who wait close to a year or even more for treatment their doctor regards as necessary.

Figure 4.4: For many procedures 5 out of every 10 people treated in a public hospital receive treatment within a month or two, for others 1 in 10 people wait a year or more.



Source: Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

In Australia, the majority of planned surgical and diagnostic procedures are performed in private hospitals. For the fifty-seven per cent of Australians who do not have private insurance they must wait their turn, according to their level of urgency, before they can undergo a planned procedure.

Although a majority of Australians don't have private health insurance, for many procedures public patients constitute a third or less of all patients undergoing that procedure

Although a majority of Australians don't have private health insurance, for many procedures public patients constitute a third or less of all patients undergoing that procedure. Examples include same-day lens procedures (only 26 per cent of procedures performed on public patients in 2006–07) and joint replacements – hip replacement without catastrophic or severe complications (33 per cent public patients) and knee replacement and reattachment (34 per cent of patients treated as public patients). For vein ligation and stripping only 34 per cent were public patients in 2006–07 and, for dental extractions and restorations, only 16 per cent were public patients.[23]

We heard a range of reasons to explain this shifting balance of surgical care provision across public and private sectors. These included surgeons electing to move increasingly or exclusively from the public to the private sector due to dissatisfaction with the public hospital work environment (a view also recently expressed by the Garling inquiry in New South Wales)[24]; views about inefficiency, lack of reliability of theatre availability and frequent and repeated patient

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[23] Derived from data published in Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

[24] P Garling (2008), Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, at: http://www.lawlink.nsw.gov.au/acsinquiry

cancellations; differences in clinical team support, equipment and facilities; perception of better engagement and respect and differences in remuneration.

> *A specialist in private practice can earn $20,000 MBS fee of 100% for a session of 10 cataract operations (equivalent to a morning's work). In the public system they would receive only $4000. This is a massive discrepancy. Are we underpaying or over remunerating? Do we need to move to a system of shared private and public practice responsibilities?*[25]

Similarly, it has been suggested that private hospitals may have also contributed to this trend by responding to market opportunity, commercial preferences for surgical activity, having a lesser role in complex medical care and teaching and seldom providing emergency services. More timely access to surgery is a strong aspect of perceived customer value of private health insurance and this may also influence private hospital activity.

Access to elective procedures is inequitable because of the differential access people have to private hospitals based on their capacity to afford private health insurance or to self-fund. The least advantaged, relying on access to public hospitals, are most likely to experience long waits for elective procedures. We heard that in public hospitals:

- The least advantaged, relying on access to public hospitals, are most likely to experience long waits for elective procedures

> *The workforce doesn't have the physical capacity to do it – if an orthopaedic surgeon decides to drop one day of work and one surgery list a week as they get older, how does the hospital fix the resulting increase in the waiting list?*[26]

Increasingly states are resorting to contracting for some procedures for public patients to be performed in private hospitals. We support this as an approach which leads to improved access to timely treatment for people relying on treatment as a public patient, to meet our proposed National Access Guarantees.

> *Shortage of workforce in some specialist surgical areas means that patients for some categories of elective surgery may experience delays. SA Health has identified specific categories of elective surgery including orthopaedics, plastics and urology where there is a relatively high risk of not meeting State targets. SA Health is working with private providers to undertake elective surgery on behalf of the public sector. A panel of private providers has been established and contracts are in place. These arrangements have enabled a positive relationship to be built with the private sector and provide additional capacity to public sector patients. Such partnerships with the private sector provide potential for the future for the public sector to look at alternative strategies for managing future demand.*[27]

In the UK the National Health Service has developed a long term and comprehensive strategy for reducing waiting times for treatment (see Figure 4.5). Like the example given above they have recently added another 'string to the bow' by procuring elective treatments from the independent sector estimated to be worth $US980 million annually (15 per cent of NHS elective procedures).

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[25] Participant (24 June 2008), National Health and Hospitals Reform Commission consultation meeting with government agencies in Melbourne.

[26] Participant (27 June 2008), National Health and Hospitals Reform Commission consultation with government agencies in Shepparton.

[27] SA Health (2008), Submission 458 to the National Health and Hospitals Reform Commission.

Figure 4.5: From more than 18 months to no more than 18 weeks – shortening elective surgery waits in the English National Health Service (NHS)

Since 1997, the English NHS has had three distinct policy phases to reduce waiting times. Between 1997 and 2000, strategies focused on reducing the total number of patients waiting while ensuring that no one waited longer than eighteen months. This was principally achieved through extra investment and sharing of best practices in waiting list management through the National Patient Action Team and Modernisation Agency.

Between 2000 and 2005, the focus moved to the maximum waiting times experienced by patients. The government set general targets (for outpatient appointments and inpatient treatment) and specific targets (for cancer). Extra (non-dedicated) funding was provided, and hospitals' performance was directly managed against published targets. The government introduced targeted initiatives to reduce waiting in orthopaedics and ophthalmology and tightened the performance management framework by introducing independent inspection and a public performance (star) rating system. The aggressive deployment of a robust performance management system alongside targets and increased funding appears to explain England's relative success in reducing waiting times.

During 2005–2008, the focus is to be on tackling the combined wait along the care pathway to achieve a maximum eighteen week wait for referral to treatment. A quasi-market is being introduced through guaranteed choices for patients, with patients able to choose providers with short waiting times at the point of referral using an information technology (IT) platform. New financial incentives are being introduced through the use of hospital activity payments based on an English version of DRGs. The government is also buying additional private-sector capacity. A program of procuring 200,000 elective treatments (worth $784 million) from the independent sector largely 'went live' in 2005. Other procurements include $392 million annually for diagnostic services and a second wave of elective procurements of $980 million annually. It has been estimated that, by 2008, around 15 per cent of NHS elective procedures will be carried out by the independent sector. In addition, budgets are being introduced for primary care physicians so that they bear some of the financial consequences of decisions to refer to a specialist.

Source: Excerpt from Willcox, M Seddon, S Dunn and colleagues (2007), "Measuring and reducing waiting times: a cross-national comparison of strategies – setting targets and national/state commitment are important to reduce surgical waiting times", Health Affairs 26 (4): 1078-1087. NB figures are in US Dollars.

Access times can be improved by measuring performance and having payment incentives for hospitals to achieve benchmarks, including in relation to timely access to care

- We believe that access times can be improved by measuring performance and having payment incentives for hospitals to achieve benchmarks, including in relation to timely access to care. It is also vital in the long term to foster a constructive and productive balance and range of services across the public and private sectors. This will be further explored in our final report.

4.3.4 Outpatient services in public hospitals

While receiving less high profile attention, another important element of services provided by hospitals is outpatient services. In this report, outpatient services refers to specialist medical, nursing and allied health care, provided to people free of charge as non-admitted patients of a public hospital.

There were reportedly 39.9 million occasions of service provided in public hospital outpatient clinics in 2006–07.[28] These data are indicative at best, as definitions vary widely between hospitals and states and territories including whether services provided away from a hospital campus are counted.

Outpatient clinics generally entail a consultation with a medical specialist and often involve investigations to aid diagnosis and management. Services from other health professionals, such as nurses, physiotherapists, dieticians, and speech therapists, may also be an essential component of a patient's outpatient care plan. Chemotherapy, radiation therapy, rehabilitation and a range of other procedures are now commonly provided on an outpatient basis. Outpatient clinics are also

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[28] Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

a vital source of continuing care for people with particular chronic conditions and follow-up care for patients discharged from an acute care episode. They are an important gateway to inpatient treatment, including for planned procedures and an important setting for clinical education.

However, many of the medical services provided in public hospital outpatient clinics are also provided by specialists privately, including consultations, diagnostic imaging and pathology. As a result there are strong financial incentives for states and public hospitals facing budgetary constraints to shift the provision of non-admitted medical care to medical specialists in private practice, as these attract an MBS rebate paid by the Commonwealth, reducing the call on public hospital budgets and state funding.

Consultations with privately practising specialists in their rooms frequently entail out-of-pocket costs, whereas hospital outpatient clinics must be provided free of charge. The same may also be true of privately-provided diagnostic services.

Importantly, private medical services generally do not provide multidisciplinary, team-based care that is available in many hospital outpatient clinics. Furthermore, the logistics of accessing private medical services can be a problem for people. Attending a hospital outpatient clinic for some services while obtaining diagnostic services from a private provider in another location can require people to engage in significant to'ing and fro'ing, requiring more time, more travel and more cost than if the services were provided in one place. This can result in poorer co-ordination of care for the patient and a higher likelihood of communication lapses between providers of care.

We note that, despite the attention cost-shifting of non-admitted patients has attracted, very little has been done to determine the impact on outcomes of care. Cost-shifting of this kind is too often about which government pays, rather than what is best in terms of providing 'good' care. In the end it is the same tax payers funding outpatient clinics as it is funding Medicare rebates for privately-provided medical services.

There is logic in the same government which funds specialist medical care also funding specialist outpatient care. Funding policy could be used to encourage multidisciplinary specialist care in community settings and promote focus on quality, efficiency and responsiveness to people's needs. For example, there are still hospital outpatient clinics which are operated on the basis of block bookings – patients have to sit and wait, often for hours.

- There is logic in the same government which funds specialist medical care also funding specialist outpatient care

> *Parents at one hospital mentioned long waiting times of up to 6 hours each week when they attended for their child's oncology treatments. They discussed this with a staff member and suggested that pagers could be made available to parents so they could take their child to the park or go to the cafeteria or collect medications etc while they waited. The parent pager system was introduced and vastly improved parent and staff satisfaction.*[29]

4.3.5 Restoring people to better health after hospital

Sub-acute care is a vital element of the patient journey, often providing the connection between acute care in hospitals and care in the community and in people's homes. It can help to improve functioning and independent daily living, reduce or slow further decline in health status, reduce unnecessary visits to hospitals, reduce the amount of time people spend in acute hospitals, and prevent premature admission for older people to residential aged care facilities. Sub-acute services are used by people of all ages.

Availability of sub-acute services is highly variable and is not adequately provided in most states, with consequent poorer outcomes (e.g. due to lack of appropriate cardiac rehabilitation) and greater use of less appropriate care (e.g. longer stays in hospital, more repeat admissions and greater use of long-term care at home or in residential care). This is expanded upon further in Chapter 5 but it is a vitally important part of our strategy to ensure that hospital resources are used wisely and people receive the best care in the most appropriate environment at the right time.

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[29] C Crock (2008), Submission 236 to the National Health and Hospitals Reform Commission.

4.3.6 Long-stay older patients

Another area which receives constant media attention, and which teeters at the interface of Commonwealth and state and territory responsibilities, is that of older people who experience prolonged stays in hospital while awaiting residential care.

The best available data on this issue comes from a census of all patients 65 or over in public hospitals on midnight of 17 April 2002.[30]

That survey obtained detailed data on 16,104 patients aged 65 or over in 99 per cent of public hospitals and found that:

- for one in five older people (19.3 per cent), another form of care was deemed by a health professional as more clinically appropriate;
- for three-quarters of these patients (which represents one in seven older patients overall), the person was in hospital waiting to access the recommended form of care;
- two-thirds of these patients (or one in eleven patients overall) were waiting to access residential aged care with very few patients waiting to access community-based care. This equates to about 1521 older persons occupying about 3 per cent of public hospital beds.

The reform directions put forward in Chapter 6 will significantly improve the responsiveness of aged care providers to meeting the needs of older people awaiting a residential care placement while in hospital.

Aged care assessment services have been established to advise on what is the most appropriate accommodation or mix of home support services for older people, whether their need emerges in hospital or at home. Earlier assessment by these services or a geriatrician can facilitate discharge planning. Better sub-acute services may reduce the demand on residential care facilities and open up other options for the older person.

The pattern of older people's use of hospitals (due to inability to access a nursing home place that meets their needs) may change significantly with the further development of transition care. In the last two years, 2228 transition care places have been allocated, with 1963 of these operational as at 30 June 2008.[31] In the 2008–09 Budget, the Commonwealth Government committed further funds to establish a total of 4000 transition care places by mid-2012. This may substantially alter the dynamics between hospital discharge and entry to residential care for those people needing the latter.

4.3.7 Transfers from residential aged care to hospitals and back again

An area in need of further improvement is the apparent difficulties encountered by older people already in residential care when they become unwell and need assistance from a doctor or health professional. Problems here are threefold:

- Some people are sent to hospital for want of care that could, and arguably should, be provided in the residential facility either by the staff of the aged care home or by visiting primary health care professionals (including GPs) if they were better able to be accessed by residents.
- Some people who should be sent for care in a hospital are not transferred when they should be (again this can be the result of shortcomings in care by the aged care facility

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[30] The full report of the survey and analysis at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-minconf.htm/$FILE/pr2report.pdf

[31] Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

but can also be the result of inadequate access to primary health care resulting in late identification of treatable conditions).

- There is evidence that some older people from residential care suffer adverse outcomes as a collateral result of hospital treatment which may have been avoided if treatment could have been provided 'in place'.[32]

Pressures on hospital beds, and a perception that residential aged care facilities are fully staffed around the clock, leads to hospitals discharging patients back to the residential facility inappropriately:

> *My mother was discharged from hospital at 3am and sent back to her nursing home in a taxi before checking with me that this is okay.*[33]

Part of the answer may lie in closer working relationships between hospitals and residential facilities with clinical staff working across the boundaries. More fundamentally, there needs to be better access to primary health care and end of life care for residents of aged care homes. Approaches to achieving both of these improvements are proposed in the reform directions in Chapters 6 and 7.

4.3.8 Continuity of care

Continuity of care between hospitals and non-hospital settings is often poor.

■ Continuity of care between hospitals and non-hospital settings is often poor

A person's usual GP, where they have one, is frequently unaware that a person has been in hospital, let alone informed of what has occurred in clinical terms during the episode or what follow-up care should be provided.

Community nursing services may not be informed, or may be informed too late to plan support in the home for a patient recently discharged. We were given the classic example of a person discharged on Friday afternoon to avoid staying over the weekend, who then has to fend for themselves over the weekend, because of limited GP availability on the weekend. Advice to the local district nursing service about the patient's discharge arrived too late to organise weekend attendance by a community nurse.

As we heard from a general practitioner:

> *Poor communication between hospitals and primary care staff in the community is a major problem in our healthcare system. General practitioners identify communication from hospitals to them as appalling. This has major implications for ongoing patient care. Involving families fully in their own healthcare will go a long way towards improving this communication.*[34]

This message was reiterated by a community pharmacist:

> *I'm a pharmacist and I'd love to see better communication coming out of public hospitals so people being discharged [have] a discharge summary.*
>
> *So that their GP knows what's changed while they've been in hospital and what they're supposed to be taking now. And so that we can then run with it rather than waiting for weeks.*[35]

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[32] T McDonald (2007), For their sake: Can we improve the quality and safety of resident transfers from acute hospitals to residential aged care? Report for the Aged Care Association Australia.

[33] Consumer (19 June 2008), National Health and Hospitals Reform Commission consultation with community in Brisbane.

[34] C Crock (2008), Submission 236 to the National Health and Hospitals Reform Commission.

[35] Pharmacist (9 July 2008), National Health and Hospitals Reform Commission consultation with frontline health professionals in Adelaide.

Discharge summaries should be more than a summary of what happened in hospital – they should be a comprehensive care plan to guide the future health care management of the patient. Discharge summaries should contain information that is relevant to all other health providers who will participate in the ongoing care of the discharged patient.

> *South Australian GPs surveyed in 2000, placed little value on the clinical synopsis and in-patient treatment but wanted information on discharge medication (and particularly new or altered medication), future hospital outpatient or specialist appointments, referrals to external agencies and any specific ongoing management they were expected to provide. They saw the summary as a referral for future management rather than a history of past management.*[36]

There are many explanations given as to why discharge summaries are not consistently provided for all patients, by all hospitals and in a timely fashion. The lack of compatible communication technologies is frequently cited. We believe it is high time that this simple issue was addressed in a system wide fashion.

4.3.9 Multi-purpose services for small towns

In rural and remote areas small community hospitals can suffer from low occupancy and difficulty attracting staff. They are also frequently significant providers of long-term (de facto residential) care for older people. Yet local hospitals were not built to be suitable places for older people to live.

There are often also opportunities in smaller communities to bring together in one setting primary health care, community care services, hospital care and aged care.

The most successful response to this has been to redevelop small local hospitals as 'multi-purpose' services which provide a mix of hospital and aged care, and often a base for primary health and community care as well. In this model the Commonwealth provides recurrent aged care funding and the facility can also be redeveloped to provide a better, more homelike environment for frail older people to live. Nevertheless such redevelopments can often strike significant resistance from local communities when it is perceived as a downgrading of the local hospital.

In Chapter 9 we propose that the model of multi-purpose services be extended to towns of up to 12,000 people.

4.3.10 Support for teaching

What distinguishes health professional education from other disciplines is the need to integrate clinical experience during the course. But the increasing pressure of immediate service needs means increasing pressure on training places to provide this clinical experience, short-term priorities thus crowding out what is essential for the long term.

Provision of adequate numbers of training places across medical, nursing and allied health professions needs to be explicitly planned, supported and funded in hospitals and ambulatory settings

- Provision of adequate numbers of training places across medical, nursing and allied health professions needs to be explicitly planned, supported and funded in hospitals and ambulatory settings.

> *Universities and technical and further education institutes (TAFEs) rely on public hospitals providing opportunities for clinical teaching of students undertaking pre-vocational and vocational training, and also for joint programs of health and medical research.*
>
> *… Public hospitals are increasingly under severe financial pressure, and any activities which are not 'core' to their 'business' and part of a funding agreement are liable to careful scrutiny.*

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[36] Clinical Information Project (2004), Phase 1 Report PART C Stream 3: National Hospital Discharge Summary, at: http://cip.healthbase.info/phase1/report/cipp1pc.pdf

> *A worrying trend is that for some public hospitals, teaching and research are now seen as somewhat discretionary.*
>
> *… Greater transparency is required in the funding arrangements supporting clinical training for both undergraduate and postgraduate students. Key to realising a streamlined clinical training system is the need to determine who is responsible for providing the training and then how it should be funded.*[37]

Exposure of trainees to an appropriate mix of cases, admitted and non-admitted, to attain competency needs to be ensured and provided across settings. This means trainees need to undertake placements wherever care is provided, including in doctors' rooms and private hospitals as well as in public hospital wards and outpatient clinics. This requires formal recognition and support for training in all relevant treatment settings.

In support of this we believe a single national body in the form of a health workforce agency – as discussed in Chapter 14 on workforce – needs to be given the authority and responsibility to determine the numbers of course places to be made available and to fund the requisite clinical placements within the health sector across all health professions.

As outlined below, we also propose that activity-based funding should be used to pay for provision of training in hospitals. Such an approach would provide the means for the proposed national health workforce agency to ensure that the required numbers of clinical placements are offered.

4.3.11 Safety and quality, clinical governance and leadership

Admission to hospital is not without risk. According to one Australian study of 14,000 patients in 28 public hospitals in two states, 0.79 per cent of hospital admissions (about one in 126) were associated with an adverse event which resulted in death.[38]

In our first report, *Beyond the Blame Game*, we identified 'promoting improved safety and quality of health care' as one of our critical challenges. Almost every state has experienced a hospital or medical safety crisis in the last five years. This suggests that safety and quality issues are not caused by idiosyncratic behaviours in individual states or hospitals but rather are the result of common issues such as credentialing of doctors, handover of care between different shifts of nurses, patient identification and systematic monitoring.

As identified in Chapter 15 of this report, strong and sustained national leadership in this area is necessary. The lead national body, the Australian Commission on Safety and Quality in Health Care, has been established as a time-limited body, with no statutory base.

- The Australian Commission on Safety and Quality in Health Care has been established as a time-limited body, with no statutory base

Leadership in promoting improvements in safety is not something that is purely the preserve of clinicians, it also needs to involve managers and patients.

> *My proposition is that no-one really runs these public hospitals in the sense that we understand how a normal organisation should function. There is a major disconnect between corporate governance and clinical governance. They very largely operate in parallel or at best in overlap. Clinical issues and risks are not given the same – or greater – attention as corporate or financial risks.*
>
> *Clinical communities need to recognise that they must play a much broader role in reforming and modernising hospitals. Senior managers must recognise that they cannot translate policy intentions into changed clinical practices. They must encourage clinicians to take on a much wider agenda including governance and work practices.*
>
> *Let me give two examples of this bottom-up approach. The first is clinical senates which have been established in many states. They make recommendations for clinical change which reflect general clinical concerns. The senates use their networks to achieve organisational reform. The*

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[37] Universities Australia (2008), Submission 461 to the National Health and Hospitals Reform Commission.

[38] R Wilson, W Runciman, R Gibberd and colleagues (1995), 'The quality in Australian health care study', Medical Journal of Australia (163): 458–471.

> *second is the Greater Metropolitan Task Force in Sydney that addresses major problems in clinical gaps, duplication and safety in Sydney hospitals. These are two examples of clinicians accepting their responsibility for reform that are integrated with organisational objectives, but these examples of clinical involvement are usually about networking between hospitals rather than within hospitals.*[39]

We propose in Chapter 15 that a permanent national body should be established and charged with leading and coordinating safety and quality in Australian health care settings. This national body should take a leadership role to help embed a culture of continuous reflection and improvement and strengthen clinical governance, including nationally consistent complaints arrangements. It should also lead the development of nationally consistent indicators to be used for monitoring quality and safety by hospitals and other providers and support providers in responding to any potential issues identified (see Figure 4.6).

Figure 4.6: Public reporting of hospital performance in Queensland

One of the outcomes of Queensland's Bundaberg Hospital scandal and the associated public inquiries was a revitalisation of quality management processes and a new emphasis on transparency in the health system. The Health Services Act 1991 (Qld) was changed in 2005 to require publication of an annual public hospital performance report. A shake-up in clinical governance also occurred, with the introduction of new quality management processes that included more robust and consistent reporting of clinical incidents and sentinel events as well as a monitoring system using statistical process control charts for 30 clinical indicators. The statistical process control approach emphasises the dynamic nature of performance against particular outcome measures and flags significant variations from the state mean. Public and private hospitals are given feedback on their performance against the indicators on a monthly basis. Depending on the extent to which a hospital's indicators deviate from the state average, there are requirements for reporting at various levels of the bureaucratic hierarchy, using a standardised approach to reporting findings that emphasises systematic reasons for variation.

What is critical in the new approach is not that an indicator is flagged for further investigation, but that robust investigation takes place. Investigation reports for indicators flagged at twice the state average rate (for non-mortality indicators, such as complications of care) or 75 per cent above the state average rate (for mortality indicators) are reviewed externally to the hospital to assess the adequacy of the hospital's internal investigation. A rating is given for the 'strength' of actions and the comprehensibility of the report for public presentation.

This dynamic and quality improvement approach to quality management was first used as the basis for the mandated public reporting in 2008. Although quantitative performance data for each of the 30 indicators for each relevant hospital are published as a separate table on the Internet, the main printed public report (also available on the Internet) focuses on whether the indicator performance of any individual hospital was significantly different from the state average and, more importantly, the actions that the identified hospital is taking in response to flagged variations from the average. A similar approach is taken with regard to reporting on clinical incidents and sentinel events.

Source: Excerpt fom S J Duckett, J Collins, M Kamp and K Walker (2008), "An improvement focus in public reporting: the Queensland approach", Medical Journal of Australia 189 (11/12): 616-617.

4.3.12 Patient experience

Quality of care is enhanced if the voices of consumers are listened to as part of routine feedback and continuous quality improvement processes. We proposed measurement of the consumer experience in our first report. Implementation of this requires the development of a nationally agreed consumer survey, to apply to public and private facilities. This should include use of Computer Assisted Telephone Interviewing (CATI) instruments to survey people about their experiences of health care.

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[39] J Menadue (2008), 'Another design problem in health: no-one runs hospitals', Presentation to the Royal Australasian College of Medical Administrators and the Australasian Faculty of Public Health Medicine New South Wales, University of New South Wales.

What is critical, of course, is not just the measurement of the experience, but that action is taken as a result of consumer feedback.

Consumer experience questionnaires should be supplemented by asking consumers about the outcomes of care they receive. Consumers seek health care to relieve pain, improve functioning and so on. The health sector describes the treatment as surgery or medical interventions, but from a consumer perspective the outcomes are measured in terms of whether they feel better, whether they experience less pain, whether they can regain their independence, and so on.

An important way of evaluating health care is to ask patients themselves to what extent their expectations have been met in terms of improvement in their condition. Standardised 'patient-related outcome measures' questionnaires have now been developed (see Figure 4.7). These include both generic questionnaires covering a range of conditions as well as condition-specific questionnaires.

- An important way of evaluating health care is to ask patients themselves to what extent their expectations have been met in terms of improvement in their condition

Figure 4.7: Measuring patient experience internationally

Instruments to measure patients' experience were developed by researchers at Harvard Medical School with funds from the Picker/Commonwealth Program for Patient-Centred Care, a program established in 1987 under the auspices of the Commonwealth Fund of New York. The aim was to explore patients' needs and concerns as patients themselves define them. . The Harvard team designed a patient feedback program derived from qualitative research designed to find out what patients value about the experience of receiving health care and what they considered unacceptable. They conducted focus groups with patients and their family members, reviewed the literature and consulted with health care professionals to determine key priorities. This research program resulted in the development of survey instruments designed to elicit reports from patients about concrete aspects of their experience. Outcomes of these surveys were reported early by Cleary et al. [Cleary, P. et al. (1991), 'Patients evaluate their hospital care: a national survey', Health Affairs 10(4):254–67].

This approach to measuring patients' experience has since been adopted for use in the Consumer Assessment of Healthcare Providers and Systems surveys in the USA, the WHO responsiveness surveys and the national NHS patient survey program in England. The Commonwealth Fund international health policy surveys of a range of countries, including Australia, also ask questions about people's experiences of the health system.

Source: M Draper and S Hill (2008), Submission 500 to the National Health and Hospitals Reform Commission.

Measurement of the patient experience should become a routine part of health service evaluation and is further discussed in Chapter 15. National standards for monitoring consumer complaints and feedback, including presentation of data, should also be developed.

4.4 Creating a better future

4.4.1 National Access Guarantees and Targets

We have proposed an array of reform directions throughout this report which will ease the pressure on hospitals and reduce waiting times for patients requiring hospital care. Nonetheless, our consultations in Australia and research about what works in other countries suggest to us that access times can be improved by measuring performance and having payment incentives for hospitals to achieve benchmarks in relation to timely access to care.

Reform direction 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.

We also propose that there be performance payments for avoiding occupancy crises, by rewarding those hospitals which avoid the consequences – namely:

- emergency department overcrowding;
- undue waiting periods for emergency treatment (using the benchmarks proposed in our first report, *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements*);
- undue waiting periods for admission from emergency department for care by other clinical staff elsewhere in the hospital; and
- hospital bypass where ambulances are redirected away from busy hospitals.

All of these are measurable, with data on them being routinely captured in most hospitals. These data should be used as the basis of performance measures at the level of hospitals.

All hospitals at risk of not meeting the National Access Guarantees and/or Targets should be assisted to develop and publish a performance improvement plan which identifies the critical blockages to achievement and specific strategies to address them.

Reform direction 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.

4.4.2 Timely provision of information on discharge

To improve the provision of information when people are discharged from hospital we propose that hospitals receive an incentive payment. The payment should be tied to the quality and timeliness of the information provided on a person's hospital care and any follow-up care required, where the person has consented to that information being provided to their nominated GP or other primary health care provider and/or the clinical staff of their aged care provider for those receiving aged care.

We suggest that, in order to receive the incentive payment, a hospital would have to achieve a rating of satisfactory or better for quality and timeliness of information from at least 80 per cent of primary health care practitioners, aged care facilities and other relevant recipients of discharge information within their vicinity.

We propose that, at a date to be set, discharge information should also be available in electronic form, according to a national standard for such information, to every person who wants it.

The financial incentive for all hospitals to provide discharge information in a standard electronic form should be that activity-based payments will not be made or will be discounted for any hospital that is unable to do so.

Reform direction 4.3

We propose there be financial incentives for timely provision of discharge information including details of any follow-up care required.

4.4.3 Paying for what's actually provided, with incentives for efficiency and better outcomes.

Hospitals are our most costly and complex health care organisations. Problems of quality or timely access to hospital care can cause the greatest public concern. In the end this requires consideration of how much is done in hospitals, and how much it costs or should cost. When people's lives and quality of life are at stake we tend to want to be sure that as much as should be done is being done. When billions of dollars are being spent, we want to be sure that the best possible use is being made of the funds. Together these imperatives raise questions such as whether our hospitals are as efficient as they could be. Could they do more with current levels of funding, or does it require more money to do more? How much more? The answers to these questions must come from a much better understanding of the relationship between what hospitals do and the levels of funding provided.

Understanding the relationship between funding and services provided is vital to improving access and to ensuring as many services as possible are provided with the available funds. That is why we propose the use of activity-based funding for all hospital services (discussed further in Chapter 13).

Activity-based funding requires an understanding of how much of what kinds of services will be provided, and what the efficient cost of providing them is. It rewards the efficient and puts the inefficient under pressure to improve. This is a critically important attribute for funding the most expensive services in our health system, and indeed those services for which expenditure is projected to grow fastest. If we are going to spend more, we should be certain that we will get more for it.

■ If we are going to spend more, we should be certain that we will get more for it

Activity-based funding provides a powerful incentive for hospitals to perform as efficiently as possible, maximising services provided for the available funds. This is a critical feature when people are waiting too long for care. Other advantages are that:

- It is person centred, in that the funding is tied to the treatment of people, not simply the funding of an organisation or the size and characteristics of a population.
- It is information rich – generating useful data on what services are provided to whom and at what cost across many different types of hospitals and services, enabling better understanding of the provision of hospital services.
- It is transparent, making clear on what basis funding is provided, with less opportunity for funding based upon influence or special pleading.

- It also increases hospital autonomy to deliver care within a clear funding and accountability framework – it separates and clarifies the role of the funder to determine, and be accountable for, the overall level of services to be provided and the level of funding to deliver those services, while requiring (and empowering) hospitals to deliver those services in the best possible way.

Because activity-based funding defines and specifies service outputs, it is also a remedy to cost-shifting. When a hospital receives a level of funding irrespective of the numbers and kinds of services it provides, there is an incentive to manage within budget by reducing service delivery and shifting provision to other providers, as this has no direct or immediate impact on its funding. Conversely a hospital can also find itself picking up the provision of services not adequately provided elsewhere, without any corresponding increase in its funding. Under activity-based funding with payment proportional to services provided, hospitals that provide fewer services by shifting provision to other providers will get less funding, while those that take on more should get more funding.

A further key strength of activity-based funding is that it can be used to pay for important hospital outputs other than treatment services. A critically important function of many hospitals is teaching health professionals. Under funding approaches that use general grants where funding is not tied to what is done, the pressure to provide services can result in resources being diverted from other important activities such as teaching. Activity-based funding can be used to define and pay for teaching. In particular, hospitals can be paid specifically for the number and kinds of clinical training placements they provide, and/or the number of completed months of training delivered, or even the numbers and kinds of students completing a recognised course.

A final strength of activity-based payment is that it can be used in conjunction with scientific evidence and economic evaluation to determine what should, and what should not, be paid for. If a particular treatment has no proven efficacy, or is less cost effective than an alternative, it is possible not to pay for that treatment under activity-based funding.[40] A crucial component of activity-based funding should be systematic use of evidence to inform what treatments qualify for payment, including hospital treatments.

Some may suggest that funding should be based on outcomes rather than activity. In principle they are right, but in practice it cannot be used as the primary basis of funding. It is technically very difficult to use outcomes to determine the base funding for a hospital, as it requires a capacity to measure outcomes reliably, to identify what part of those patient outcomes the hospital is responsible for, and to work out the precise cost of producing those outcomes efficiently.

For these reasons paying for outcomes or performance is best done as incentive payments at the margin, where outcomes, or at least the processes that reliably lead to good outcomes, can be identified and measured and are clearly attributable to the hospital. The amounts paid based upon outcomes may be only a small fraction of the cost of providing hospital services, but often such marginal payments can be quite influential in rewarding good practices and service delivery.

Overall, we believe hospital funding should be predominantly activity based, using nationally standard approaches, augmented by some use of payment for performance.

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[40] S Nicholson, M Pauly, A YA Wu and colleagues (2008), 'Getting Real Performance Out of Pay-for-Performance', The Milbank Quarterly 86 (3): 435–457.

Reform direction 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.

Activity-based funding for public hospitals should recognise the role of those who work in hospitals in determining how best to organise and deliver the various elements of an episode of care. In support of this we believe activity-based funding for public hospital care should be for whole episodes of care classified using casemix classifications – in particular Australian Refined Diagnosis Related Groups (AR-DRGs) for acute, admitted patient care; and classifications such as the Victorian Ambulatory Care System (VACS) for outpatients, and the Casemix Rehabilitation and Funding Tree (CRAFT) or Sub-acute, Non-acute and Palliative care (SNAP) classifications for sub-acute care and rehabilitation.

Emergency departments cannot be funded purely on an activity basis, as they are required to be available even when activity is low. Accordingly we propose that emergency departments be funded using a mix of a fixed grant for availability and a variable component related to activity, using a casemix classification. Similarly, hospitals with a major emergency load need to have stand-by bed capacity and on-call staff, irrespective of whether any person requires admission or the specific skills present on a given day. These costs, similar to the availability costs of emergency departments, need to be recognised in funding.

4.4.4 Improving outpatient care

To remove the incentive to shift costs, we suggest there is merit in having the same government fund specialist medical care provided privately in the community and specialist outpatient care provided in public hospitals. This will enable a much clearer focus on the relative health benefits of each care option and allow greater innovation in location and setting of specialist care. This reform direction is explained in more detail in Chapter 12.

This would create the opportunity for the development of policies and funding for outpatient clinics that is not driven primarily by cost shifting between governments, but rather has regard to achieving outcomes for people needing the kind of care provided by outpatient clinics. It will also enable a sensible appraisal of the best combination of outpatient clinics and private medical services for achieving health service outcomes. And with the Commonwealth also responsible for policies and funding for primary health care, it should enable the development of more integrated approaches to the provision of both primary and secondary care.

Many ambulatory services provided by hospitals do not require the expensive overheads inherent in inpatient provision. Over the last few decades, services which previously required inpatient care have been decentralised to community settings (renal dialysis and some outpatient services being examples). Decentralising these services can reduce travel time of those attending and, because they are of smaller scale, can provide a less institutionalised, more person-centred service.

Reform direction 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.

4.4.5 Reporting on quality

> *A system that cannot openly scrutinise its processes, decisions and outcomes is unable to learn from what works and what does not and is therefore compromised in its capacity to implement improvements. For there to be open scrutiny, there must be reporting, and that reporting must be in a format that is understood and accessible. Only then can the system, services and individuals be held accountable. Accountability and transparency are essential parts of safety and quality.*[41]

As noted in Chapter 15, the Australian Healthcare and Hospitals Association has strongly advocated a nationally mandated 'balanced scorecard' of key performance indicators for the health of the entire nation. They emphasise the importance of timely feedback to the place of service delivery as well as to higher levels within the system – national, state/territory, area region.[42]

Reform direction 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.

Women's Hospitals Australasia[43] and Children's Hospitals Australasia[44] also advocate for the national collection and analysis of key performance indicators to allow speciality hospitals in each state to compare results on patient outcomes and care processes. They note that peer pressure has been shown to be one of the most effective levers in changing practice and improving outcomes. This type of peer group benchmarking also encourages sharing of knowledge and best practice and reduces duplication of effort.

Reform direction 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.

These performance measures should be based upon indicators developed by the Australian Commission on Safety and Quality in Health Care and should include nationally standard methods of surveying people on their experience as patients (see Reform direction 15.6).

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[41] Australian Council on Safety and Quality in Health Care (2008), Submission 428 to the National Health and Hospitals Reform Commission.

[42] Australian Healthcare and Hospitals Association (2008), National Data and Benchmarking.

[43] Women's Hospitals Australasia (2008), Submission 436 to the National Health and Hospitals Reform Commission.

[44] Children's Hospitals Australasia (2008), Submission 435 to the National Health and Hospitals Reform Commission.

4.4.6 Improving information for service design

One of the challenges to understanding the outcomes of health care in Australia and the relationship between hospital care, primary health care and aged care is that there is no linkage between hospital 'episode' data and care provided elsewhere. One solution to this, nationally, would be for public and private hospital episode data (inpatient for public and private, emergency department and outpatient for public hospitals) to be collected nationally with the patient's Medicare card number wherever available. These data could be provided direct to Medicare Australia, which has a 33-year track record of handling health information on Australians without incident.

This would provide a capacity to understand the use of hospitals by people, and also, through the use of the Medicare card number, would capture longitudinal data on people's use of medical benefits, pharmaceutical benefits, public and private hospitals and potentially aged care (residential and community care packages).

This would be enormously useful in understanding the relationship between use of GPs, use of specialists, use of prescription pharmaceuticals, use of hospitals and use of aged care. It would also enable monitoring of indicators such as avoidable admissions and unplanned re-admission to hospital even where this occurs at a hospital other than that which provided initial treatment.

A further benefit is that the program of voluntary Indigenous identification in Medicare Australia's data, that has been running for some years now, would provide powerful longitudinal and comparative data for a large sample of Aboriginal and Torres Strait Islander people – and it would do so without people needing to repeatedly re-identify to each service, each time they present.

Arguably being able to understand people's use of health services across settings and over time is a basic building block to support design of person-centred health care.

- Being able to understand people's use of health services across settings and over time is a basic building block to support design of person-centred health care

Reform direction 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.

These data should be routinely provided to the Australian Institute of Health and Welfare to undertake its work in reporting on Australia's health and health care. In addition, samples of de-identified data linked across all services should be made readily available to researchers to facilitate health services research

4.4.7 Balancing emergency and planned care

In the case for change we discussed separately two problems of timely access to hospital care – in emergency departments and for elective procedures. These are often competing objectives for hospitals, as improving performance on one can come at the expense of performance on the other. A critical issue for public hospitals is the need to balance provision of emergency care and planned admissions.

Maintaining bed occupancy at no more than 85 per cent to ensure ready admission from emergency departments can mean scheduling even fewer planned admissions for elective procedures.

Even following the best practices in managing bed availability, the need to use operating theatres and clinical staff at very short notice for patients admitted through emergency departments can disrupt the provision of scheduled procedures, requiring planned operations to be cancelled and rescheduled.

Patients admitted for emergency treatment are also significant users of other resources essential to the post-operative care of people undergoing planned surgery, such as intensive care, coronary care and high care units. The need to use these for an unplanned admission can also lead to a need to rescheduling of planned procedures, even when operating theatre time is still available.

Cancelling and rescheduling a planned procedure is highly disruptive for people in need of the procedure, who necessarily have to organise their lives around the planned procedure, and then have to reorganise again. In addition, to prevent a cascade of rescheduling, other planned operations cannot simply be rescheduled to give priority to the person who has suffered a cancellation. This means that a person suffering a cancellation may have to wait for some time before their next opportunity to have the planned procedure.

These disruptions can also apply to the clinical staff, who may have their operating theatre session sidelined by the need for a different clinical team to operate on an emergency patient.

This is a problem that in Australia is essentially limited to public hospitals, as very few private hospitals have emergency departments and those that do tend not to deal in the most serious cases such as major trauma. This is one of the reasons why private hospitals are good places to do planned procedures, because most of the caseload of private hospitals is planned admissions. In addition many private hospitals operate at significantly lower levels of occupancy than larger public hospitals, so even where there is a need to admit a patient urgently, it is less likely to disrupt the hospital's capacity to deliver planned care.[45] This is why contracting for the performance of planned public patient treatments in private hospitals can be effective in ensuring timely access to care.

One approach which can be very effective for the delivery of both planned and emergency care in public hospitals is to have specialised planned procedure hospitals or centres. This strategy has been used successfully in other countries and was recommended by many during our consultation.

> *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.*[46]

This separates completely the facilities and staff responsible for providing planned procedures from those providing emergency procedures. Understandably this model is only practicable where there is a sufficient volume of both kinds of cases to make full use of separate facilities and staff.

These can be 'hospitals within hospitals' – in similar fashion to day surgery suites in public and private hospitals. That is, specialised planned procedure units can be established as separate facilities as part of a larger hospital and co-located in the same precinct, an example being The Alfred Centre in Melbourne.[47] But it is also possible to achieve the same effect in cities with many hospitals by designating particular hospitals as being dedicated to planned procedures. This would entail relocating any emergency department capacity to another hospital in reasonable proximity.

Such developments require regional planning and the careful delineation of hospital roles and facilities across multiple sites. Undertaking this is well beyond our scope; however, we do suggest that consideration be given to further planning and development of specialised facilities for planned procedures in Australia's major cities. While investment criteria for public and private services are often different, hospital developments are expensive and it is therefore important that duplication of facilities between the public and the private sector be avoided. This also has implications for planning emergency hospital capacity, as mentioned earlier.

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45 Based on data in Australian Institute of Health and Welfare (2008), Australian Hospitals Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra), the national average occupancy of public hospitals is 86 per cent while for private hospitals, not including standalone private day hospitals, the figure is 76 per cent.

46 Royal Australian College of Surgeons, Submission 406 to the National Health and Hospitals Reform Commission.

47 At: http://www.baysidehealth.org.au/Department.aspx?ID=284

Reform direction 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.

4.4.8 Clinical leadership and governance

> *There should be effective systems of clinical governance at all levels of the health system to ensure continuous improvement in the safety and quality of health care. Good clinical governance makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement.*[48]

A key feature of new national clinical governance arrangements should be development of national clinical standards and approval of nationally endorsed care pathways (see Chapter 15). A national approach must be taken to ensure that the best available evidence is used in patient treatment, wherever a patient is treated and by whichever professional. This means that care paths for common conditions need to be available and followed. Financial incentives will also play a part here through practice improvement payments (the term used in the USA is 'pay for performance'). Nationally developed and agreed clinical standards should be a core feature of new facility accreditation arrangements proposed by the Australian Commission on Safety and Quality in Health Care.

Safety and quality can only be improved if the Australian health care system acknowledges errors and learns from mistakes. We need to promote and encourage a learning culture in health care, through research and reflection.

But things do go wrong in hospitals and patients are harmed. The first step in moving forward is to recognise that accidents happen – they are in fact 'normal'.[49] There is no serious scholar of safety and quality today who doesn't advocate a 'systems approach' to learning from mistakes, slips and errors and this is what most health systems and health facilities attempt to follow.

A systems approach, though, is not about a 'no fault' approach, as sometimes a professional's actions are 'blameworthy'; for example, when working under the influence of drugs or when involved in criminal activities as occurred with Harold Shipman.[50] Nevertheless, what must be pursued is a 'just culture'. A tragedy involving a patient can't and shouldn't be ignored, but a witch-hunt shouldn't be the starting response.

- A tragedy involving a patient can't and shouldn't be ignored, but a witch-hunt shouldn't be the starting response

Building a quality performance dimension into local service structures and employment agreements will also help concentrate the attention of both health professionals and managers. Indeed there is a growing realisation of the importance of using government funding levers to hasten the reform agenda in safety and quality. We believe that as a starting point financial incentives to reward continuity and quality of care should be adopted. In Chapter 14 we have identified the importance of ensuring a motivated and engaged clinical workforce. We have suggested clinical senates (already existing in SA and WA) as a possible means of achieving that at a state level. The same issue is relevant at the national level: that national policy is formulated with systematic input from clinicians – medical and non-medical.

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[48] Australian Council on Safety and Quality in Health Care (2008), Submission 428 to the National Health and Hospitals Reform Commission.

[49] C Perrow (1984), Normal Accidents: Living With High Risk Technologies (Basic Books: New York).

[50] J Smith (2002), The Shipman Inquiry, UK. Harold Shipman was a general practitioner in England who diverted narcotics for his own use and to murder his patients. He is estimated to have killed 215 people.

A further method of engagement on specific issues including those identified in this report would be the establishment of clinical networks as is already happening in a number of states and territories.

> *A series of Statewide Clinical Networks are being established to increase the level of clinicians' involvement in the planning of health services, to find ways to better coordinate the delivery of those services, to ensure better health outcomes for all South Australians and to ensure a strong, sustainable health workforce.*
>
> *These networks will link doctors, nurses, allied health professionals, GPs and community representatives to better work together to assist in fully integrating service provision across hospital sites and GP Plus Health Care Services. For example, the Cancer Clinical Network will explore ways in which country people can receive the majority of their cancer care closer to home. This could be receiving chemotherapy at home or visiting their local specialist. The Orthopaedic Clinical Network will work to identify ways to prevent falls among the elderly and ways in which increased access to elective orthopaedic surgery can be achieved.*
>
> *Clinical Networks will also have a key role in improving the performance of our hospitals by improving safety and quality, reducing the length of hospital stays to national benchmarks, reducing emergency department waiting times and working with community-based services to allow patients to be discharged from hospitals where appropriate and receive care at home.*[51]

Reform direction 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.

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[51] South Australian Government (2008), South Australia's Health Care Plan 2007–2016, attachment to Submission 458 to the National health and Hospitals Reform Commission.

5. Restoring people to better health and independent living

Key messages

- Sub-acute care is a vital element of the patient journey, often providing the connection between acute care in hospitals and care in the community and in people's homes. It can help to improve functioning and independent daily living, reduce or slow further decline in health status, reduce unnecessary visits to hospitals, reduce the amount of time people spend in acute hospitals, and prevent premature admission for older people to residential aged care facilities. Sub-acute services are used by people of all ages.

- Sub-acute care includes services such as rehabilitation, geriatric evaluation and management, new programs such as Transition Care and other 'step-up' or 'step-down' programs. These services need to work hand-in-glove with other services such as respite care, community nursing, and home and community care support services. Sub-acute services are, and should be, a 'broad church'. They will often involve multidisciplinary teams, with strong input from a range of specialist allied health staff.

- Many sub-acute services should be community-based (that is, outside hospitals) to promote improved access. This is also consistent with the different philosophy and treatment approach of sub-acute services which focus on improving independent functioning in the context of people's daily lives and health conditions.

- Many parts of Australia have limited or poorly developed sub-acute care services. The inability of many patients to access a comprehensive range of sub-acute services represents a significant 'missing link' in the care continuum. This service gap seriously erodes the effectiveness of other services, such as acute hospital care, as well as causing poorer outcomes for patients. An ageing population and increasing chronic disease will further strain our already under-developed sub-acute services.

Our reform directions

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.

Sub-acute services are sometimes known as the 'invisible services' or the 'missing link'

Sub-acute services are sometimes known as the 'invisible services' or, as described to us during our consultations, 'the missing link'. When we think of the continuum of care needed by some people, sub-acute services provide the 'glue' that connects acute care provided in hospitals with community care provided in people's homes.

> *While sub-acute care is a crucial investment for an integrated health system, it is largely absent from the national discourse about health policy. Utilisation and financial data for sub-acute services are rolled up into acute care statistics and thus invisible in national data sets.* [1]
>
> *Rehabilitation medicine has long been the poor cousin of the medical world. A few hours of life saving neurosurgery is nearly always given media and administrative precedence over the six or nine month rehabilitation program.* [2]
>
> *With the bed access issue we need access to more rehabilitation beds and we also need better community services. But better community services won't do away with the need for the sub-acute beds.*[3]

Another defining feature of sub-acute services is that the best results are achieved when there is a shared partnership between the individual (and their family and carers) and health care professionals. Rehabilitation is not something that is 'done' to 'patients'. It requires the active participation and responsibility of the individual to work towards improving their health and ability to function as independently as possible.

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[1] Australian Healthcare and Hospitals Association (2008), Submission 35 to the National Health and Hospitals Reform Commission.

[2] Australasian Faculty of Rehabilitation Medicine (2008), Submission 21 to the National Health and Hospitals Reform Commission.

[3] Rehabilitation specialist (18 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health workers in Brisbane.

Or, in the words of the Australasian Faculty of Rehabilitation Medicine:

> *By encouraging newly disabled people to take control of their own destiny, rehabilitation medicine ensures that the person is the 'hero' of their rehabilitation program, not the doctor, therapist or nurse.* [4]

5.1 Defining and scoping sub-acute care

Sub-acute services are hardly the stuff of animated conversations over a Sunday barbeque. If an opinion pollster were to ask ten people for their views on sub-acute services, it is highly unlikely that even one of them could correctly define what the term means, let alone identify the issues impacting on this important part of the health service care continuum.

Even within the health sector and between states and territories, there are quite different understandings and language used to describe sub-acute services. To cut through this bureaucratic Babel tower of definitions, we began by specifying the outcomes that we were seeking to achieve for people and their families from sub-acute services. These outcomes include:

- to improve the functional capacity or the ability of people to live their lives as healthily and as productively as possible;
- to slow the decline in health status or reduce complications arising from an illness or injury;
- to reduce unnecessary admissions to hospital that could be avoided if people had better access to services that slowed the progression of their condition or dealt more pro-actively with their symptoms;
- to allow older people time and space to recover from health problems so that they are not admitted prematurely to a residential aged care facility. This is the case both for older people in the community and older people in hospitals, where high levels of so-called 'nursing home type' patients may actually signal gaps in sub-acute services; and
- to ensure that the care that comprises sub-acute services is provided in the most suitable setting (usually not an acute hospital ward) with the right mix of staff and other resources.

The scope of services that might help to achieve these better outcomes for people includes at their core rehabilitation and geriatric evaluation and management services. Sometimes such care may be known colloquially as 'low dependency' or 'step-up' and 'step-down' care. Transition Care is the formal name for one relatively new Commonwealth/state program that helps support older people through providing flexible packages of care for up to 12 weeks following an acute episode in hospital. Sub-acute services are characterised by the use of multidisciplinary teams, with strong reliance on specialist allied health staff and medical specialists including rehabilitation medicine specialists and geriatricians.

■ Sub-acute services are characterised by the use of multidisciplinary teams, with strong reliance on specialist allied health staff and medical specialists including rehabilitation medicine specialists and geriatricians

Sub-acute services may be provided on an inpatient basis, but are also commonly available on an ambulatory or non-admitted basis (for example, weekly cardiac rehabilitation programs for patients recovering from a heart attack). In some states, inpatient sub-acute services are provided in separate facilities to acute hospitals, while in other states they may be provided in the same or separate wards of acute hospitals. Sub-acute care may also be provided directly in people's homes. Sub-acute services cover the full gamut of physical and mental health conditions, although sub-acute services related to mental health are discussed later in Chapter 10. Similarly, examination of palliative care services (often viewed as one type of sub-acute service) has been held over until Chapter 7 which considers issues relating to end of life care.

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[4] Australasian Faculty of Rehabilitation Medicine (2008), Submission 21 to the National Health and Hospitals Reform Commission.

Finally, we have not included in our above working definition of sub-acute services some other services that may frequently be provided in association with sub-acute services. Respite care, community nursing and home and community care support services are all vital elements in 'connecting care' for patients and their families. But they differ from sub-acute services that take a more active role in working with patients to restore health and they use a different mix and intensity of specialist and allied health staff.

5.2 Building on our strengths

In recent years, governments have been working to lift the policy focus on, and investment in, sub-acute services. The three most significant national developments have been:

- From 2003 onwards, the Commonwealth Government provided $253 million under the 2003–2008 Australian Health Care Agreements Pathways Home program so that states and territories could expand the provision of step-down and rehabilitation services through investing in capital and infrastructure support for these services.
- In 2004, all governments committed to a National Action Plan[5] to improve the care of older people across the acute-aged care continuum. This included agreement to developing planning guides to define adequate levels of services including rehabilitation, geriatric evaluation and management and other specialised health services.
- In 2004, the Commonwealth Government introduced the new Transition Care Program with an expected annual budget of $150 million to achieve better integration between acute hospitals and the aged care sector. This program is intended to improve the functional capacity of older patients to keep them at home as long as possible.

However, a hard-nosed assessment would suggest that progress has been disappointingly slow, with little in the way of measurable improvements for patients in terms of better access to sub-acute care arising from these efforts. In part, this may reflect the size of the gap, given historical underinvestment in sub-acute services. But, it may also reflect that the additional investment has not been clearly tied to additional service delivery and that governments have not been held fully accountable for their commitments under the National Action Plan.

There are now good data available that demonstrate that rehabilitation services are improving outcomes for patients receiving such care ■

A more positive development has been the establishment of the Australasian Rehabilitation Outcomes Centre in 2002 (see Figure 5.1). While there is an absolute dearth of published data on the level and provision of sub-acute service delivery, there are now good data available that demonstrate that rehabilitation services are improving outcomes for patients receiving such care (see Figure 5.2).

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[5] Information on the National Action Plan, including annual reports, is available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-hcoasc.htm

Figure 5.1: National data on health service outcomes can be collected through collaborative non-government arrangements

The Australasian Rehabilitation Outcomes Centre (the Centre) is a joint initiative of rehabilitation providers, funders (governments, private health insurers, and transport and accident insurers), regulators and consumers. The Centre collects and releases data on the outcomes of care for most patients receiving rehabilitation services in public and private hospitals across Australia.

Eschewing the usual government-led model for collecting and reporting health system performance data, the Centre was established by the Australasian Faculty of Rehabilitation Medicine and operates as a not-for-profit organisation. It is a rare working model in the Australian health system of a data collection that:

- *covers both public and private health care providers; and*
- *provides benchmarking data back to individual hospitals to allow them to understand (and improve) their performance on clinical rehabilitation outcomes relative to their peers; and*
- *includes robust data on the actual outcomes for patients through the use of the Functional Independence Measure (FIM) that was developed with strong clinical input; and*
- *is currently developing performance data for the ambulatory (non-admitted) setting as well as continuing to report outcomes of rehabilitation services provided to hospital inpatients*

Although the Centre is voluntary in nature and partly funded through a user-pays model, the clear benefits of this data collection have meant that over 90 per cent of public and private inpatient rehabilitation services are members and submit data.

Source: Australasian Rehabilitation Outcomes Centre, About AROC, at: http://chsd.uow.edu.au/aroc/

Our primary focus in highlighting the example of the Australasian Rehabilitation Outcomes Centre is to showcase one innovative model of encouraging the collection and use of health outcomes data. Of course, a single model does not necessarily meet all of the reform directions that we canvass elsewhere in this report around better information for people. For example, we are proposing the publication of benchmarking data that allows the community to assess the relative performance of individual health services in improving health outcomes for people. We also want to encourage the creation of more 'person-centred' data that consolidates information on health status and health service use of an individual across all settings. But, the Australasian Rehabilitation Outcomes Centre does highlight the value of working with clinicians to develop and use outcomes data.

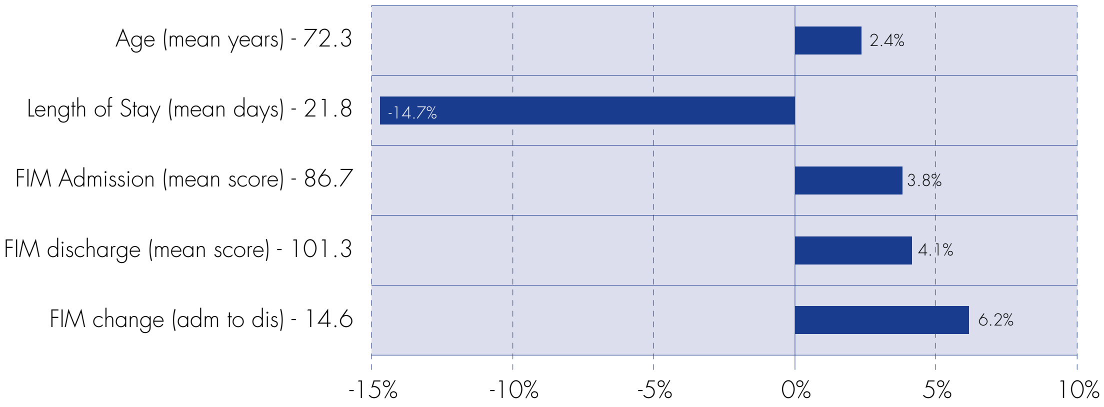
Figure 5.2: Patient outcomes, following use of rehabilitation services, have improved in recent years

The Australasian Rehabilitation Outcomes Centre (the Centre) is now reporting annually on the outcomes for patients receiving rehabilitation services.

The outcome measure used is the Functional Independence Measure (or FIM). This measures a person's ability to carry out an activity independently, versus the need for assistance from another person or device. The FIM comprises a mix of elements related to motor skills (such as bathing, dressing, walking, use of stairs) and cognitive skills (such as problem solving, memory and social interaction).

The Centre collects data on the FIM score when people are admitted to rehabilitation (admission score) and discharged from rehabilitation (discharge score). The FIM change measures the change (improvement or deterioration) in functional independence during the period of rehabilitation.

The data collected by the Centre for 2007 comprises about 50,000 rehabilitation episodes provided that year and it covers 90 per cent of inpatient rehabilitation facilities. In its analysis of trends since 2000, the Centre has identified that the average time spent in rehabilitation has declined by almost 15 per cent (from 21.8 days in 2000 to 18.6 days in 2007). However, more importantly, the outcomes for patients have improved with a higher change or positive score on the Functional Improvement Measure, once rehabilitation has been completed.



Source: Unpublished data provided by the Australasian Rehabilitation Outcomes Centre in November 2008.

5.3 Identifying the case for change

A major challenge in identifying what needs to improve in the sub-acute services area is the woefully inadequate data that are available. Hence, this is the first issue we have targeted for reform.

5.3.1 Improving access to information on sub-acute services

The best available national data on sub-acute services are now six to eight years old. These data were collected as part of a series of one-off surveys and research projects commissioned under the Care of Older Australians Working Group (the Working Group), a joint Commonwealth and state committee that reported to all Australian health ministers.

The data commissioned by the Working Group identified that:

- Over the 1990s the number of rehabilitation and assessment beds had declined relative to population growth, falling from 3.2 beds per 1000 population aged 70 years and over in 1992 to only 2.4 beds per 1000 population in 2001. However, it was also reported that access to these services had not been adversely affected, with waiting times to access rehabilitation and assessment services equivalent or better in 2001 than they were in 1992.[6]
- The majority of older people (80 per cent) receiving care in public hospitals were considered to be in the appropriate setting and receiving the right type of care. Among the remaining 20 per cent of patients, it was determined that about two-thirds had been recommended and should have been receiving residential aged care, while about one-third should have been receiving another type of hospital care such as rehabilitation or geriatric evaluation and management.[7]

The authors of one of these studies cautioned in 2002 about the 'substantial challenges of undertaking a national project in the context of limited available routine data' and expressed the hope that another one-off project would 'not need to be repeated' in the future.[8] Unfortunately, it appears that this situation remains unchanged in 2008.

In 2004, Australian health ministers signed up to the previously mentioned National Action Plan (the Plan) to improve care across the continuum of hospitals and aged care services. The Plan identified actions which were the responsibility of state and territory governments and actions that were the responsibility of the Commonwealth Government. Specifically in relation to sub-acute services, the Plan committed states and territories to the following actions:

- first, to define by June 2005, what the standards or planning guides should be for the required level and type of sub-acute services; and
- second, by June 2008, to introduce measures to progressively meet the required levels of sub-acute services identified through these planning processes.

Yet, as of October 2008, there is almost no information available on the planning guides (if any) being used by states and territories to determine the required levels of sub-acute services, nor has the Commonwealth Government set any national benchmarks which states are required to meet in providing sub-acute services. The release of Annual Reports that identify progress under the National Action Plan has ceased, or at least slowed to a snail's pace (the most recent report is for 2005–06). No government – whether state or Commonwealth – is being held accountable for non-performance against their previous commitments.

■ No government – whether state or Commonwealth – is being held accountable for non-performance

This situation is clearly at odds with the views we expressed in our first report, *Beyond the Blame Game*. There is little chance of improving access to any type of service unless we can, first, measure whether the service is actually being provided and, second, set benchmarks for improved performance.

5.3.2 Expanding access to sub-acute services

In this data vacuum it is clearly difficult to be definitive. But the expert consensus among health professionals working in our health services, and governments and hospitals involved in funding and managing patient care, is that there is a need to expand significantly the provision of sub-acute services.

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[6] L Gray, M Dorevitch, R Smith and colleagues (2002), Service provision for older people in the acute-aged care system, Final Report, at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-minconf.htm/$FILE/1bfinalreport.pdf

[7] Aged Care Evaluation and Management Advisors (2003), Examination of length of stay for older persons in acute and sub-acute sectors, Final Report, at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-minconf.htm/$FILE/pr2report.pdf

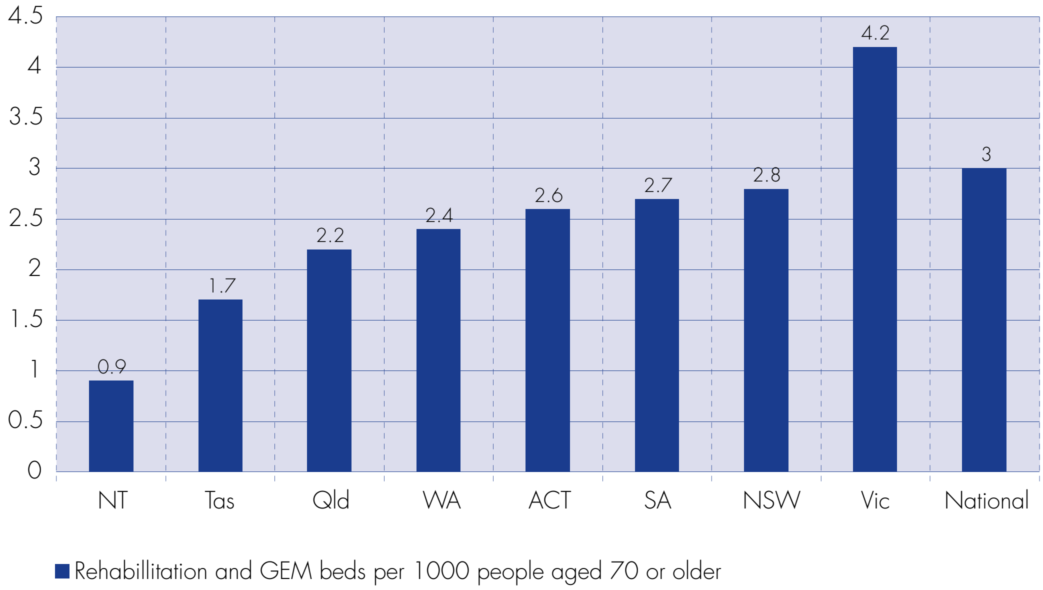
[8] L Gray, M Dorevitch, R Smith and colleagues (2002), Service provision for older people in the acute-aged care system, Final Report, at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-minconf.htm/$FILE/1bfinalreport.pdf

The Australasian Faculty of Rehabilitation Medicine (the Faculty) has estimated that the number of rehabilitation beds needs to increase by 43 per cent, equivalent to an extra 1870 rehabilitation beds.[9] We note that the Faculty's benchmarks may be conservative as they not adjust for population ageing, nor do they attempt to measure the need for ambulatory rehabilitation services or other types of sub-acute services such as geriatric evaluation and management or transition care.

Where you live is likely to influence whether you get access to necessary sub-acute services

Data on the distribution of rehabilitation and geriatric evaluation management beds indicates that where you live is likely to influence whether you get access to necessary sub-acute services. Victoria has at least 50 per cent more beds adjusted for population than the next best performing jurisdictions (New South Wales, South Australia and the Australian Capital Territory) and a huge 150 per cent more beds than its southern neighbour, Tasmania (see Figure 5.3). The Faculty has also identified even greater disparities in access to rehabilitation medicine specialists across Australia. Western Australia and Queensland have a particularly low supply of rehabilitation specialists, with most of these specialists being found in New South Wales, Victoria or the Australian Capital Territory.[10]

Figure 5.3: There is unequal access to sub-acute services across states and territories



Source: Derived from Table 4.3 in: Flinders Consulting (2008), National Evaluation of the Transition Care Program, Final Evaluation Report, at:

http://www.health.gov.au/internet/main/publishing.nsf/Content/13539979243E2556CA2574BB00152A2E/$File/TCPEvaluReport.pdf. Note: GEM is geriatric evaluation and management.

We have also been alerted to potential disparities in access to sub-acute services between patients using public and private hospitals.

> *Older patients in private hospitals do not generally have access to the sub-acute, post-acute and transition care services that are funded through public hospitals or the Commonwealth aged care program.*[11]

However, the evidence on this question is not clear-cut. The Australasian Rehabilitation Outcomes Centre has reported that in 2006 more patients using sub-acute services were actually being

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[9] Australasian Faculty of Rehabilitation Medicine (2008), Submission 21 to the National Health and Hospitals Reform Commission.

[10] Australasian Faculty of Rehabilitation Medicine (2008), Submission 21 to the National Health and Hospitals Reform Commission.

[11] A Howe (2008), Submission 222 to the National Health and Hospitals Reform Commission.

managed in the private sector than the public sector. But, the public sector 'tended to treat a greater percentage of the most impaired patients'.[12]

Other submissions highlighted access gaps for particular types of sub-acute services. In their joint submission, the National Heart Foundation of Australia and the National Stroke Foundation identified major gaps in use of effective sub-acute services for patients after a heart attack or a stroke[13]. They found that:

- The World Health Organization and the Heart Foundation recommend that all patients who have had a heart attack, heart surgery or have other heart or blood vessel disease are routinely referred to a suitable cardiac rehabilitation and prevention program. But a study in one Australian state found that 70 per cent of such patients did not get access to a cardiac rehabilitation program.
- About one-quarter of people hospitalised after a stroke need inpatient rehabilitation, but there is a lack of comprehensive stroke services providing both hospital and ongoing community rehabilitation. Moreover, only 16 per cent of hospitals surveyed in 2007 could provide access to early discharge and comprehensive home-based rehabilitation services which have been shown to be clinically effective for certain patients after a stroke.

Similarly, the Australian Lung Foundation has suggested that the approximately 200 pulmonary rehabilitation programs across Australia are likely to be much less than what is needed to improve the quality of life for patients with chronic obstructive pulmonary disease. It identified that such programs are not provided in rural locations outside the larger regional centres, while a single pulmonary rehabilitation program services the whole of the Northern Territory.[14]

It is noteworthy that all these conditions – coronary heart disease, stroke and chronic obstructive pulmonary disease – are part of what is often referred to as the tsunami of chronic disease. And yet our health services are not even meeting the existing demand for effective rehabilitation services for today's patients with chronic diseases.

■ Our health services are not even meeting the existing demand for effective rehabilitation services for today's patients with chronic diseases

5.3.3 Providing new models of sub-acute care – the right mix and the right setting

To date, we have examined traditional bed-based sub-acute services and we have focused mainly on rehabilitation services. We want to stress, however, that we believe that sub-acute services can and should comprise a very broad array of services to provide care in many settings.

The approach being developed in Victoria to providing care for patients needing a hip replacement provides one such example of more sub-acute services being available in the community (see Figure 5.4). Victoria is already recognised as having a very well-developed public sub-acute services system. In addition to comparatively high access to rehabilitation beds, Victoria has an extensive network of sub-acute ambulatory services including:

- community rehabilitation centres – facilities that are usually separate from acute hospitals where people can participate in rehabilitation programs;
- home-based rehabilitation; and
- a range of early intervention, assessment and management clinics – these include clinics where people can be assessed for dementia, receive support in helping to reduce the risk of falls and improve mobility, or learn to better manage chronic pain while living in the community.

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[12] F Simmonds and T Stevermuer (2008), 'The AROC annual report: the state of rehabilitation in Australia 2006', Australian Health Review, 32(1): 85–110.

[13] National Heart Foundation of Australia and the National Stroke Foundation (2008), Submission 402 to the National Health and Hospitals Reform Commission.

[14] Australian Lung Foundation (2008), Submission 39 to the National Health and Hospitals Reform Commission.

Within this network of ambulatory services, Victorian patients needing a hip replacement now typically may have 11 days as an acute hospital patient, 14 days as a sub-acute inpatient, followed by an eight week community rehabilitation program. Victorian health services are beginning to test new models of care involving much greater provision of rehabilitation in the patient's home. This has the potential to not only achieve better outcomes, but to do so with a more effective use of resources and with a greater emphasis on care in the community.

Figure 5.4: Victoria is developing new care pathways for people needing a hip replacement

🟥 Usual pathways: 25 inpatient days; $24,500 🟦 Better care pathways: 4 inpatient days; $19,500

Source: Information provided to the National Health and Hospitals Reform Commission by the Victorian Department of Human Services, October 2008

Note: OWL is the Orthopaedic Waiting List project that involves a prioritisation tool and greater use of the allied health workforce in assessing the need for orthopaedic surgery.

A second issue relates to the better assessment and care of frail, older people. This is 'core business' for sub-acute services. The challenge is not just to manage and support older people once they have an acute episode, but to intervene early and provide good structures that support older people in their homes. We were very encouraged, in our consultations and in the submissions, by the many examples shared with us about better ways to provide care and support for older people (see Figure 5.5). A critical element of many such programs is the use of evidence-based assessment tools to better identify problems and options for future care. Another important feature is the use of multidisciplinary teams with strong use of generalist staff. This is vital in being responsive to the multiple health problems of older people and taking a holistic approach, rather than a single-disease approach.

Figure 5.5: Health and aged care services across the country are developing better ways to care for and keep older people healthy

In Queensland, staff at the Gold Coast Hospital have developed the Aged Care Early Intervention and Management Program. This involves a close working relationship between the hospital and 60 residential aged care facilities. Older patients who are admitted to the hospital are intensively case-managed, with these staff acting as the 'sons and daughters' to actively manage the care of very frail and vulnerable patients during their hospital stay. There is extensive use of standardised assessments to monitor health outcome and functioning. However, this program also works to actively intervene and reduce hospital admissions or visits to the emergency department for this population. Hospital staff provide outpatient care to residents living in aged care facilities, while the hospital has also provided extensive training and support to nurses working in these 60 aged care homes. This program has reduced by 83% the number of visits to hospital emergency departments by older people.

In the Australian Capital Territory, the RADAR (Rapid Assessment of the Deteriorating Aged at Risk) program is also working to intervene early in caring for older people. GPs are able to refer at-risk older people to a team comprising two nurse practitioners and a geriatrician who assess and manage them before they need a hospital admission. Close liaison occurs with the patient's GP to maintain continuity of care. While this model is still being trialled in the ACT, it has resulted in fewer and more appropriate admissions to hospital, with less time in hospital for those who are admitted.

Sources: Gold Coast Hospital Early Intervention Management (2008), Submission 7 to the National Health and Hospitals Reform Commission.

The Australian Nurse Practitioner Association (2008), Submission 14 to the National Health and Hospitals Reform Commission.

5.3.4 Ensuring the right resources to deliver high quality, effective sub-acute services

A key part of all health service delivery is having a high quality, well trained workforce and the right infrastructure and support in which health services can be provided to people.

We do not have very good information on the workforce that delivers sub-acute services, nor on future workforce needs to respond to both the growing demand for sub-acute services and a likely shift to more community-based provision of service.

The Australasian Faculty of Rehabilitation Medicine argues that there is a 'significant mal-distribution problem'.[15] The number of rehabilitation medicine specialists varies from about 1 for every 46,000 people in New South Wales to about 1 for every 344,000 people in Western Australia. The Faculty suggests that there is a need for national workforce planning and the development of national service planning standards for rehabilitation. Geriatricians are another critical group involved in the provision of sub-acute services. There is very limited information on the availability and distribution of geriatricians, either in hospitals or in community-based settings.

Two other critical elements of effective sub-acute services are our allied health workforce and access to necessary aids and equipment. Both these elements are obviously relevant to effective service delivery across the whole of the care continuum. But, they are especially vital for effective sub-acute services as they enable and support more care to be provided in the community and help people function independently at home.

■ Two other critical elements of effective sub-acute services are our allied health workforce and access to necessary aids and equipment

Like sub-acute services, the allied health workforce suffers from a low visibility and does not attract the same policy spotlight as the medical and nursing workforce. The Australian Health Workforce Advisory Committee has identified that further work is necessary 'to clearly define the allied health workforce and the professions that constitute that workforce'.[16] We note with interest the work being undertaken by Services for Australian Rural and Remote Allied Health, in developing a framework that identifies a range of groupings within the allied health workforce.[17] This framework seems to capture the breadth of the allied health workforce including clinical and therapeutical allied health professionals, public health professionals, health workers and therapy assistants and the complementary health workforce.

Submissions[18] identified a range of issues about our knowledge of the allied health workforce including:

- Workforce data collection is largely limited to professions which are registered nationally. Some allied health professions are registered in only some states (such as occupational therapy, dietetics, speech pathology) and this poses major challenges in building a comprehensive picture of the allied health workforce.
- Much data on the allied health workforce is quite dated. For example, the most recent data available on physiotherapists is based on data collected in 2002–03.

Aids and equipment are a core element of many sub-acute services and are required on an ongoing basis by some people to allow them to live independently. This includes a very wide range of items such as wheelchairs, walking frames, lifting devices, shower chairs, home modifications, as well as items that are used regularly by some people, such as feeding tubes, oxygen, and compression bandages. But, access to aids and equipment is highly variable across

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[15] Australasian Faculty of Rehabilitation Medicine (2008), Submission 21 to the National Health and Hospitals Reform Commission.

[16] Australian Health Workforce Advisory Committee (2006), The Australian allied health workforce – an overview of workforce planning issues, Report 2006.1, at: http://www.nhwt.gov.au/documents/Publications/2006/The%20Australian%20allied%20health%20workforce.pdf.

[17] S Lowe, R Adams and A O'Kane (2007), A framework for the categorization of the Australian health workforce – a discussion paper, Services for Australian Rural and Remote Allied Health.

[18] For example: Australian Rural Health Education Network (2008), Submission 43 to the National Health and Hospitals Reform Commission.

Australia, with many people missing out.[19] Not only are there different programs and eligibility rules between states, but the 'rules' also vary across different programs and groups of people (such as people accessing services under the Home and Community Care program, veterans, and people whose care is being funded under accident- or work-related compensation schemes). We will return to this issue later in Chapter 13 where we examine the impact on families of the often high costs associated with aids and equipment.

In addition to items that may have been partially funded under 'traditional' aids and equipment programs, we also note the growing potential of assistive technology to make an important contribution to the care of some people, including the elderly or those with a disability.

> *New developments in assistive technology are likely to make an important contribution to the care of elderly people in institutions and at home. Video-monitoring, remote health monitoring, electronic sensors and equipment such as fall detectors, door monitors, bed alerts, pressure mats and smoke and heat alarms can improve older people's safety, security and ability to cope at home.*[20]

The area of assistive technology is one where our technological capabilities (see Figure 5.6) may quickly outpace our existing service and funding arrangements. The need for evidence-based introduction of new technologies, driven by cost-effectiveness, is also further considered in Chapter 13.

Figure 5.6: Assistive technology has the potential to improve independent living

In its submission, Independent Living Centres Australia argues that a national Assistive Technology Program is needed to take a holistic approach to people's needs, including both physical and psychosocial wellbeing.

Assistive technology is rapidly changing and sometimes it may seem closer to the stuff of science fiction or our imagining of the future. But, according to a report commissioned by Alzheimer's Australia South Australia, the 'future is now' with robotics and new devices already available to help with independent living. Some examples cited in this report include:

- *A GPS tracking device has been developed specifically to help manage the 'wandering' that is a common symptom of some people with dementia. Apart from the usual features of being able to locate the position of the person carrying (or in this case wearing) the device, this model also has a 'breadcrumbing' feature. This allows the ability to identify favourite routes that the person may follow. An automatic locate feature can be scheduled to see where the person is at any given time.*
- *Japan is a leader in so-called 'smart toilets'. According to one of the companies involved:*

> *You may think a toilet is just a toilet, but we would like to make a toilet a home health measuring centre.*

Devices or measuring instruments that are being fitted to toilets include:

- *a toilet seat equipped with electrodes that sends a mild electric charge through the person's buttocks to measure their body-fat ratio;*
- *a small spoon with a retractable, mechanical arm can be used to collect urine and measure the level of sugar present; and*
- *voice prompts and speech recognition to prompt the person through the various steps involved in home health monitoring.*

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[19] Motor Neurone Disease Australia (2008), Submission 114 to the National Health and Hospitals Reform Commission.

[20] F Miskelly (2001), 'Assistive technology in elderly care', Age and Ageing, 30: 455–458.

Figure 5.6: Assistive technology has the potential to improve independent living

- *Another product helps people with short-term memory loss manage their medications. It can be programmed with 60 medication cups that can be dispensed 1–6 times per day. It includes verbal prompts with a calendar clock triggering an alarm when it is time for the person to take their medication. The medication is only dispensed or released when the person presses the button on the sounding of the alarm. If the person does not press the button, the device can be programmed to contact a nominated carer via the internet. As medication can only be accessed according to the programmed alarms, it also helps reduce problems associated with over-medication when people forget they have taken their medicines already.*

Sources: Independent Living Centres Australia (2008), Submission 469 to the National Health and Hospitals Reform Commission;

Tim Wallace (2005), Life enhancing technology: Assistive technology for people living with dementia, at: http://www.alzheimers.org.au/upload/LifeEnhancingTechnologyWallace.pdf

5.4 Creating a better future

We believe that the critical challenge is the need to improve access to a range of effective sub-acute services. The underpinnings of how to achieve this require significant shifts in how we fund, organise and manage the delivery of sub-acute services. In other words, we cannot continue with a 'business as usual' approach.

■ The critical challenge is the need to improve access to a range of effective sub-acute services

Existing funding arrangements between governments provide no clear accountability, nor set desirable levels, for the delivery of sub-acute services. This is also currently true for acute hospital services, but these services (such as elective surgery or cancer treatment) are often the subject of public reporting by governments and the media. They are also more likely to be the beneficiary of new funding initiatives.

In contrast, sub-acute services generally fly under the radar. Even within individual jurisdictions, funding and reporting arrangements for sub-acute services are less well-developed than for acute hospital services. States currently use a variety of approaches to how they fund sub-acute services including:

- block grants (with no relationship between the level of funding provided and the level of sub-acute services delivered);
- bed day payments (for each day in a sub-acute inpatient facility);
- casemix type payments (with a variety of casemix classifications used across states); and
- other funding arrangements such as payment for outpatient visits, or the number of allied health staff.

Governments have recently agreed to move towards the use of activity-based funding (such as casemix) for acute hospital services under the next Australian Health Care Agreements. There is a risk that these new funding arrangements may not extend to sub-acute services due to the lack of agreed classification and funding systems for sub-acute services. If this happens, the need for a growing investment in sub-acute services is likely to be threatened.

Reform direction 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.

The development of activity-based funding models for sub-acute services is critical in ensuring that there is a transparent 'value for money' relationship between spending and the delivery of services that can help restore health and independence. However, we see activity-based funding for sub-acute services as only the first step in funding reform to improve access to sub-acute services.

The existence of a data collection on patient outcomes after rehabilitation provides a real opportunity to introduce funding related to better outcomes (so-called 'pay for performance' funding which is further discussed in Chapter 13). This could occur through providing incentive payments that recognise a successful outcome (better functioning for patients). It could also drive 'bundling' together of all necessary services to provide a successful outcome for patients. That is, the product or outcome paid for by governments (and by private payers such as health insurers) might be 'better mobility for patients with hip problems' with the payment covering all the required services on this care continuum (assessment, surgery, rehabilitation, aids and equipment and community care). Such payment reforms should, of course, be driven by clinical evidence and guidelines (including relevant national service improvement frameworks) on effective models of care to improve patient outcomes. We note, for example, the evidence on the efficacy of stroke units which are currently underprovided across Australia and could play a major role in early assessment and long-term rehabilitation of people suffering from a stroke.[21]

Reform direction 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.

Over and above greater transparency in how sub-acute services are funded, there is a need for additional investment, on both a recurrent and capital basis, to expand the provision of sub-acute services. Decisions about the level of such additional funding should be guided by clear targets that indicate the required level of sub-acute services. The development of planning standards (that could inform targets) should have occurred under the National Action Plan and is now three years overdue. Our advice is that at least two states (Victoria and New South Wales) have commissioned work on planning frameworks and demand models for sub-acute services. However, there is no imperative to drive national agreement or implementation of a common set of planning standards and benchmarks on the level of sub-acute services.

Reform direction 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.

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[21] National Heart Foundation of Australia and the National Stroke Foundation (2008), Submission 402 to the National Health and Hospitals Reform Commission.

We would expect additional funding for expanded sub-acute services to be closely linked to the use of clear benchmarks and activity-based funding. This required focus on performance and outcomes would appear to be compatible with the framework being negotiated for the National Partnership Payments.

We have already mentioned that activity-based funding should include the cost of capital. As discussed later in Chapter 13, these capital costs are essentially about the replacement of existing infrastructure and equipment. However, this approach is not sufficient to meet the cost of new capital investment in sub-acute services. It is evident from Figure 5.3 that there has been substantial under-investment in sub-acute inpatient beds in many states and territories. There will also be a need for capital investment in ambulatory or community-based rehabilitation in other centres or facilities close to where people live.

■ It is evident that there has been substantial under-investment in sub-acute inpatient beds in many states and territories

Reform direction 5.4

We propose that investment in sub-acute services infrastructure be one of the top priorities for the Health and Hospitals Infrastructure Fund.

Investment in additional infrastructure for sub-acute services must be tied to the ability to clearly measure the additional capacity and/or improved access to sub-acute care arising from such funding. The unpublished evaluation of the $253 million Pathways Home capital investment program under the last Australian Health Care Agreement is likely to provide useful lessons to improve the design of future capital investment in sub-acute services. We note, as further discussed in Chapter 13, that additional capital expenditure may be sourced from either governments or the private sector.

In addition to funding, sub-acute services need a skilled workforce and access to suitable equipment to support people in their restorative journey to better health and functioning.

Reform direction 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.

Reform direction 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.

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6. Increasing choice in aged care

Key messages

- Aged care services need to become more responsive to the needs of older people and their families. Existing regulatory and funding arrangements mean that older people often do not have much choice about the type of care they will receive or whether such care is provided at home or in an aged care service.
- There will be huge growth in demand for aged care services. Some of this is due to our ageing population, particularly the growth in people aged 85 years or over. But other factors also contribute to a growing demand for aged care services. This includes changing disease patterns (such as dementia) and reduced access to carers and family support due to changes in social and economic circumstances.
- There has been a change over the past two decades, so that more aged care services are now provided in the community. Different charging arrangements, assessment processes and program rules reduce the flexibility of how care is provided to people receiving community aged care.
- The regulated limits on the supply of aged care places constrain choice for people. There are very low vacancy rates in aged care homes, so that when people need to enter an aged care home at short notice they may often have little choice.
- Care is sometimes not well-connected for older people, as they move between hospitals and residential aged care services. There are also gaps in access to primary health care and end of life care for people living in aged care homes.
- The focus of aged care in the future should be on funding people and their needs rather than places.

Our reform directions

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.

> *The distinctive feature of … aged care … is that it combines care and treatment, in various ways, with housing and social support services. Residential aged care is where 170,000 older Australians live and involves all three of these services. Community care supports up to a million more to live in their own homes with various combinations of care and support.*

> *In many countries this system is referred to as 'long term care' to distinguish it from the short term or episodic care that more typically characterises the health system. People go to health services to 'get something done' and then leave. By contrast many older people live in, or live supported by, aged care. Their health needs are supported in those settings.*[1]

In this chapter, we tackle the complex issue of aged care in its own right, as well as the relationship of aged care to the rest of the health system. For many people, 'connecting care' across hospitals, primary health care and aged care is one of the most important, but most difficult, challenges they will experience in their life.

Our terms of reference specifically require us to report on 'a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to … better integrate acute services and aged care services, and improve the transition between hospital and aged care'.

We argue that aged care needs to be more responsive to the needs of older people, and that this is essential to improving older people's quality of life in aged care, and to improving the productivity and efficiency of delivery of aged care. Central to this is ensuring an increased supply of high quality, efficiently delivered aged care.

6.1 Defining and scoping aged care

Many people will have personal experience of aged care services, either for themselves or family members. One in every three men and one in every two women who live to the age of 70 will subsequently enter residential aged care.[2] Many more will receive support at home through either the joint Commonwealth-state Home and Community Care (HACC) program or Commonwealth community aged care packages.

■ One in every three men and one in every two women who live to the age of 70 will subsequently enter residential aged care

On 30 June 2008, there were about 160,000 people in residential aged care, another 40,000 in Commonwealth community care, and more than half a million older people receiving Home and Community Care (and another 250,000 younger people with disabilities).[3]

Most aged care services are delivered by the private or non-government sector. For residential aged care:

- Most (60 per cent) is provided by private not-for-profit organisations (primarily church and charitable organisations).
- One-third (33 per cent) is provided by private for-profit organisations.
- The rest is provided through state governments (5 per cent) and local governments (2 per cent).

In contrast, community aged care services are predominantly provided by private not-for-profit or government providers (95 per cent).[4] In other words, there is very little for-profit provision of community aged care services.

The Commonwealth funds about 70 per cent of the cost of residential aged care, and more than 90 per cent of the cost of community care aged care in its own programs. The balance is met by individuals. The Commonwealth provides about 60 per cent of the funding for HACC, with the balance coming from states and territories (including some from local government).

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[1] Aged and Community Services Australia (2008), Submission 6 to the National Health and Hospitals Reform Commission.

[2] D Cullen (2007), 'The financial impact of entering aged care', Australasian Journal on Ageing 26 (3): 145–7.

[3] Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

[4] Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

6.2 Building on our strengths

Our aged care system has a number of important strengths.

One very important change in recent years has been the shift to funding more aged care services in the community. Targets for aged care provision have been revised over the past two decades to encourage greater community-based service provision (see Figure 6.1). The availability of Commonwealth-funded community aged care has increased from zero in 1990 to more than 46,000 places in mid 2008, including more than 6000 high-level community care packages – Extended Aged Care at Home (EACH) and Extended Aged Care at Home – Dementia (EACHD). This means that people have more choice about whether they receive aged care services through admission to a residential aged care service or through getting these services at home in the community.

Figure 6.1: The target for total aged care places has increased and shifted from residential to community care from 1985 to 2007

Year	Residential high care places	Residential low care places	Total residential places	CACP packages	EACH & EACHD packages	Total community packages	Total aged care places & packages
1985	40	60	100	..	..	..	100
1992	40	55	95	5	..	5	100
1993	40	52.5	92.5	7.5	..	7.5	100
1995	40	50	90	10	..	10	100
2004	40	48	88	20	..	20	108
2007	44	44	88	21	4	25	113

Source: Productivity Commission (2008), Trends in Aged Care, compiled from several published sources.

Note: CACP stands for Community Aged Care Package
EACH stands for Extended Aged Care at Home packages
EACHD stands for Extended Aged Care at Home packages for people with dementia

Much of community and residential aged care in Australia is of a high standard, provided by a conscientious, trained workforce. There have also been dramatic improvements in the quality of residential aged care buildings in the last decade with single room accommodation and ensuite bathrooms now the norm for new facilities. Most aged care homes are accredited for three years.

6.3 Identifying the case for change

6.3.1 Meeting future demand

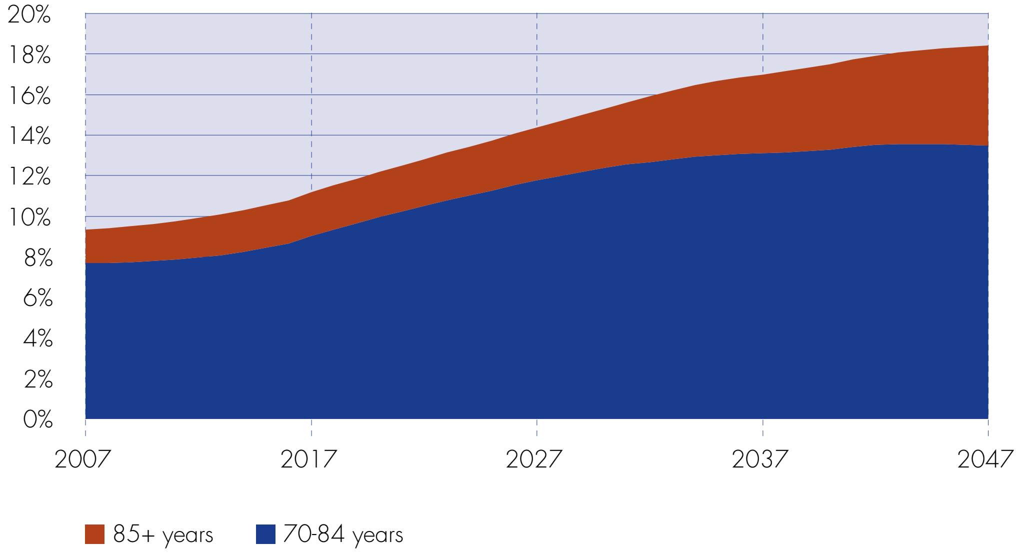
In 40 years, the proportion of people aged 85 or over will triple, and the numbers of people aged 85 or over will quadruple

In 40 years, the proportion of the population aged 70 or over will double. In the same time, the proportion of people aged 85 or over will triple (see Figure 6.2). If we express this in terms of the actual numbers of people (not the shares of the population), the numbers of people aged 70 or over will almost triple, and the numbers of people aged 85 or over will quadruple.

The implications of an ageing population for our need to increase aged care services are challenging. The Commonwealth currently aims to provide 113 aged care places (including residential and community care) for every 1000 people aged 70 or more. What this means is that:

- in June 2008 there were 223,107 aged care places across Australia;[5] but
- by 2020, we will need 337,500 aged care places (an increase of 51 per cent); and
- by 2030, we will need 464,000 aged care places (an increase of 108 per cent over current levels).[6]

Figure 6.2: Older people will be double as a proportion of the population in the next 40 years



Source: Australian Bureau of Statistics (2008), Population Projections Australia

We also need to remember that factors other than population ageing will influence the demand for aged care services. Some of these other factors include:

- If life expectancy continues to increase, more people will live well into their eighties. Dementia is much more common among people in their middle to late eighties. Dementia is a major cause of people seeking entry to aged care, with one estimate being that about half of people in residential care have dementia.[7]
- The trend to smaller families, and the higher incidence of marital breakdown in recent decades, may reduce the availability of 'informal care' for older people in future.
- Continued increases in workforce participation by people of working age may also reduce the availability of informal care.

■ Factors other than population ageing will influence the demand for aged care services

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[5] Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

[6] Calculated by applying the target ratio to the projected population aged 70 or over, using Series C from: Australian Bureau of Statistics (2008), Population Projections Australia (Commonwealth of Australia: Canberra).

[7] Australian Institute of Health and Welfare (2007), Dementia in Australia, national data analysis and development (Commonwealth of Australia: Canberra).

The current provision of aged care in the community depends heavily for many people on Commonwealth-funded aged care being supplemented by informal care, usually provided by family members. If access to informal care declines, provision of aged care in the community may be challenged. What does this mean for older people and their families?

An older person receiving a Community Aged Care Package (CACP) receives an average of about seven hours a week in personal care. Many older people receiving aged care under these packages can live independently with no additional help. But 75 per cent of older people who are severely limited in their daily activity and living conditions (more than three severe or profound core activity limitations) rely on the support of an informal carer.[8]

People with more high care needs may receive Extended Aged Care at Home packages (including EACH dementia) which typically provide about 18 to 22 hours of assistance each week.[9] Even in this situation, many such people will need other support throughout the day. For people with dementia, the presence of a carer is important not only to assist with activities of daily living, but also for their safety depending upon the severity of their condition.

In simple terms, less access to care and support by family or other informal carers means that older people are more likely to need to enter a residential aged care service, rather than living at home.

6.3.2 Improving responsiveness and choice for people

The aged care system is incredibly complex, with people having to make difficult, life-changing decisions, often at short notice ■

The aged care system is incredibly complex, with people having to make difficult, life-changing decisions, often at short notice. Older people seeking support themselves, and younger people who have had to navigate the aged care system on behalf of a parent or relative know only too well the complexity of the decisions and the immense amount of information that has to be quickly absorbed. Some of the issues and questions that people face include:

- Will we have to sell the family home?
- What are the different levels of charges and how will this impact on pensions and other financial matters?
- How can we get reliable information about the quality of the care provided by a particular aged care service?
- Can we 'try out' a particular aged care home? Can we change to another aged care home if the first one doesn't work out? How long are we likely to have to wait for our preferred aged care home?
- What if mum or dad wants to stay at home? What services are available and will they be accessible at the right times and provide the right mix of services?

Older people and their families often do not know what services are available, and have difficulty finding out how to obtain information on services, let alone the services themselves.

> *I cared for my severely incapacitated husband for 12 months, all by myself, until I recently became aware of support services. The services are excellent – but accidentally discovering their existence and availability was the problem. We had no idea of what was available, how to seek them out. I might add it is a 'maze' working out what agency does what and how.* [10]

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[8] Australian Institute of Health and Welfare (2004), Community Aged Care Packages Census 2002 (Australian Institute of Health and Welfare: Canberra).

[9] Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

[10] Council on the Ageing (2008), Consultations on in-home services for older people final report to Office for the Ageing (OFTA) for 2008–2011 home and community care triennial plan.

This remains true despite a number of initiatives to make access to information easier, both over the phone and on-line:

- Commonwealth Carelink Centres – regional information sources with a single free telephone number nationally – 1800 052 222; and
- http://agedcareaustralia.gov.au/, which includes an on-line home finder.

There are no widely available measures of quality of care and quality of life for older people trying to choose an aged care home or provider.

The complexity of the aged care system also means that sometimes it feels like the classic line from Henry Ford – 'People can have the Model T in any colour – so long as it's black'. Some examples include:

- People receiving aged care services at home may have no choice in who provides their care. They may also not be able to keep the services of a trusted aged care provider if they are 'reclassified' and access higher funding packages. (That is, a person who may be funded for HACC services might have to start again with another aged care provider if they progress to needing more care under a Community Aged Care Package).
- The level of funding support for people receiving aged care services in the community is 'locked' into different packages, rather than being based on a scale where need for services might increase incrementally. That is, a Community Aged Care Package (CACP) provided an average of about $12,684 annually to support care. The next 'level up' is an Extended Aged Care at Home (EACH) package that provides over $42,000 annually. There are no middle tiers of community care for people requiring more than a CACP, but less than an EACH package.
- There is often very little choice when people need to move at short notice from home to a residential aged care service. Nationally, residential aged care services operate on average with a vacancy rate of about six per cent. [11] Vacancy rates tend to be lower in metropolitan areas; for people requiring high-level care; and for people seeking a place in an aged care service run by the charitable sector.

For many people, getting access to aged care services that meets their needs at home or in aged care that suits them can be difficult. This applies to both residential and community aged care services.

■ For many people, getting access to aged care services that meet their needs at home or in aged care that suits them can be difficult

The rigidity of how the aged care system operates is very different to our expectations about choice in other aspects of our lives. As the baby boomers age, it is likely that people will expect more choice, not less, in how they are able to receive aged care services when they need them. An important emerging concept is that of 'consumer-directed care' (see Figure 6.3). Under consumer-directed care, people have more say in deciding what services best meet their needs and which providers they want to receive these services from.

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[11] Department of Health and Ageing (2008), Report on the operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

Figure 6.3: Under consumer-directed care, people have more say about what care they get from whom

Consumer-directed care is a term used to refer to an approach to obtaining care for frail older people and people with disabilities, under which the person needing care is given direct control over the resources provided for their care. This can take several forms. It can range from simply providing the person requiring care with a sum of money which they can spend as they wish, through providing them with a budget and some management support, but with few restrictions on how the budget may be spent, to providing them with a budget which can only be spent on indentified services delivered by approved providers.

Internationally there are programs in place which are examples of all of these different approaches.

- *Austria introduced major policy reforms in both the aged and disability sectors in 1993 and consumer-directed care became available to everyone needing ongoing support. In 2004, 300,400 people used self-directed care: this constituted 4 per cent of the population. Approximately 90 per cent of consumers self-directed their care while living in the community, while the remainder were in residential care. Consumer-directed care was available to all adults regardless of their type of incapacity, and 45 per cent were aged over 80 years. The number of people using consumer-directed care has increased sharply in recent years.*
- *A particular program in the UK provided a man with multiple sclerosis and poor vision with funds to be used as he wished. This attracted some attention when he chose to spend some of the funds on a football season ticket and hiring a companion to take him to the football each week and describe the action on the field and then take him to the pub after the game. He was highly satisfied with the arrangement, as was his wife, who said 'It gives me the only time I get off all week and I don't have to watch football in the wet and the cold'.*

In general the critical design considerations in consumer-directed care seek to balance freedom for the person needing care against protections against the misuse of the funds, and the administrative responsibilities that it can place on the person managing their own care.

Consumer-directed care has been available in Australia for disability care in a variety of specific projects for some time, but is not widespread. There has been discussion of possible use of consumer-directed care in community aged care in Australia but there are no programs currently in place.

Note: This outline of consumer-directed care uses information from a discussion paper: C Laragy and G Naughtin (2008), Discussion Paper on Increasing Consumer Choice in the Aged Care Sector (Research and Policy Centre Brotherhood of St Laurence).

6.3.3 Connecting care for people between hospitals and aged care

Another major set of issues relates to how services work, or don't work, as older people move between hospitals and aged care services. While our primary concern is always about the impact on people, we also know that poor 'connections' for people as they move through the health and aged care system can result in problems with the effectiveness and efficiency of care.

First, we consider the issues that arise for older people who are in hospital and are assessed as needing an aged care service, either in an aged care home or in the community.

Older people use hospitals more frequently, and have longer stays in hospitals, than the general population

On average, older people use hospitals more frequently, and have longer stays in hospitals, than the general population. This is entirely to be expected, given that they have more health problems and generally take longer to heal and recover from treatment than younger people. (However, extended lengths of stay by older people in hospitals are often viewed as one of the factors contributing to over-stretched capacity, with the lack of beds then impacting on whether people can get admitted to a bed from the hospital's emergency department.) A crisis such as changing care needs or the loss of support of a family member (including the death of a spouse who has been the primary carer) can also precipitate the need to receive aged care services.

What often seems to happen in these circumstances is that there is a mismatch between the pressures under which hospitals operate and the difficulty in making decisions and finding access to the right aged care services in a timely fashion.

One response to this challenge has been the establishment of the Transition Care program (see Chapter 5) that provides care for older people leaving hospital who have been assessed as needing aged care services. This operates like a 'bridging' service between hospitals and aged care services, providing access to a low intensity therapy, personal and/or nursing care to help people recover and improve their confidence and independence after a hospital stay.

Another important factor is whether older people have access to the right level and mix of sub-acute services, including rehabilitation and geriatric evaluation and management services. We noted in Chapter 5 that a shortage of these services means that older people run the risk of being prematurely admitted to a residential aged care service. That is, some older people are not given sufficient opportunity to participate in rehabilitation, improve their functioning and so return to living at home.

■ It is likely that the move from hospitals to residential aged care will continue to be a 'bottleneck'

Even with the addition of Transition Care and better access to sub-acute services, it is likely that the move from hospitals to residential aged care will continue to be a 'bottleneck'. To put this in quantitative terms:

- Hospitals are 'high volume' and 'high turnover' businesses. On average, three and a third million people each year stay at least one night in hospital.[12] This means that on average, on any one day, about 9000 people will be discharged from hospital (excluding those who receive their treatment on a same-day basis). More than a quarter of all hospital episodes are for people aged 70 or over, and about an eighth are for people aged 80 or over.
- Residential aged care services are 'low turnover' businesses. About 60,000 people leave permanent residential aged care in a year (not including respite care). This means that, on any one day, about 160 newly vacant beds become available across Australia. About 70 of these are filled by people entering residential aged care directly from the community. So, on any one day, only about 90 residential aged care places are filled by older people leaving hospital.

A reduction in the number of older people having a prolonged stay in hospital while awaiting a residential care place essentially requires a higher level of vacancies in residential care to improve availability and choice. This, in turn, requires changes to the current restrictions on the supply of aged care places.

A second area for further improvement is in health and hospital care for people already in residential care. Problems here are threefold:

- Some people are sent to hospital for want of care that could, and arguably should, be provided in the residential facility. This includes care that could either be provided by the staff of the aged care home or by visiting primary health care professionals (including general practitioners), if they were better able to be accessed by residents, or hospital outreach services.
- Some people who should be sent for care in a hospital are not transferred when they should be (again, this can be the result of shortcomings in care by the aged care facility but can also be the result of inadequate access to primary health care, resulting in late identification of treatable conditions).
- There is evidence that some older people from residential care suffer significant, avoidable adverse care outcomes as a collateral result of hospital treatment.

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[12] Australian Institute of Health and Welfare (2008), Australian Hospital Statistics 2006–07 (Australian Institute of Health and Welfare: Canberra).

6.3.4 Connecting care – primary health care and end of life care for people receiving aged care

Access to primary health care also needs to be improved for some residents of aged care homes. The trend to increased average frailty among older people is placing pressure on the capacity of aged care services to meet care needs adequately.

There is inadequate access to primary and specialist medical care and nursing care, including palliative care. As advised to us by ACT Health:

> *ACT Health wishes to draw the attention of the National Health and Hospitals Reform Commission to the urgent need for an organised approach to primary care for people in residential aged care facilities. If a systematic approach can be achieved it will improve safety and quality and enable residents in aged care facilities to access more coordinated care. This would support them in the facility or community and reduce the need for acute care.*[13]

Recent increases in payments for general practitioners attending people in residential care may improve access to medical care for aged care residents. However, the problem is not simply a matter of levels of remuneration. Aged care homes often lack facilities, such as a consulting room, to support general practitioners in their work.

We discuss in Chapter 7 issues related to the need to provide better support for people at the end of life. Access to both generalist and specialist palliative care support needs to be improved for people living in residential aged care services. There is also evidence to suggest that too many older people are transferred from their aged care home to hospital for interventions that they would prefer not to have. The National Aged Care Alliance has argued that:

> *Unnecessary hospitalisation and failure to respect people's care preferences are potentially avoidable through planning for future care that is done in a considered way involving the person, their care team and, optimally, their family, carers and loved ones.*
>
> *Broader application and implementation of advance care planning will require greater awareness and knowledge among treating practitioners to support the development of advance care plans, greater coordination across and among service providers to support the effective implementation of advance care plans, and enhanced community understanding of advance care plans.*[14]

6.3.5 Understanding the impact of existing regulatory and funding incentives in aged care

Reform of aged care services for people requires tackling how aged care is regulated and funded ■

While our focus is on people, many of the issues identified in Sections 6.3.1 to 6.3.4 are inextricably linked to the existing regulatory and funding incentives under which the aged care system operates. Reform of aged care services for people requires tackling how aged care is regulated and funded.

Accordingly, we want to briefly describe some of the main features of existing regulation and funding of the aged care sector.

Aged care is highly regulated. The Commonwealth Government regulates the supply of aged care places, specifying a target for the number of aged care places per thousand people aged 70 or over. It also regulates or controls the 'demand' for aged care services through the use of Aged Care Assessment Teams (ACATs). ACATs act as the gatekeeper for aged care services, with people requiring an assessment in order to be rated as eligible for aged care services. This regulatory framework is designed to ensure that public expenditure on aged care services is limited to those genuinely needing care.

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[13] ACT Health (2008), Submission 5 to the National Health and Hospitals Reform Commission.

[14] National Aged Care Alliance (2008), Submission 453 to the National Health and Hospitals Reform Commission.

Restrictions on the number of aged care places limit choices for older people. They result in an aged care sector with high occupancy: there is little real opportunity for people to move between aged care services; and people often feel they must take the first available place, rather than wait for their preferred facility, especially if they are waiting for aged care in a hospital. There is little incentive for aged care providers to be entrepreneurial and responsive to older people and their families – essentially, they have a 'captive market' – and no matter how well they provide care, they cannot increase their market share simply by attracting a larger number of older people, as they cannot simply expand existing facilities or open new ones due to restrictions on places.

- Restrictions on the number of aged care places limit choices for older people

Aged care funding is also complex and highly regulated.[15] Because supply is constrained, most charges are also regulated so that providers cannot take advantage of scarcity to charge higher prices. In residential aged care, there are essentially two kinds of payments: those related to care and those relating to living and accommodation expenses. In community care there are only payments for care.

In residential care, payments for care are determined, using the Aged Care Funding Instrument (ACFI), in three parts according to need for support for activities of daily living (such as bathing, dressing eating and so on), a behavioural supplement and a supplement for complex health care. This results in 64 different levels of payment up to a maximum of $171.43 per day.

People in residential aged care can be asked to contribute up to a maximum of $58.15 per day to their care fees on a sliding scale depending on their income. A person's government-funded care subsidy is reduced in proportion to their capacity to pay. Full pensioners pay nothing towards their care fees.

In addition to any care payment, the maximum charge (basic daily fee) for living expenses for all residents is set at 85 per cent of the single basic aged pension or $32.95 per day.

The type of accommodation charge a person may be asked to pay depends on whether they enter for low-level residential aged care (formerly hostel care) or high-level care (formerly nursing home care). People entering for low-level care can be asked to pay a lump sum bond, while people entering for high-level care cannot – they can only be asked for a daily fee.[16] Apart from small bonds, most of a person's bond is refunded when they leave care.

Under the regulations the limit on accommodation bonds is the level of the person's assessable assets less an amount equal to 2.5 times the annual single basic rate of pension (this equates to $35,500 at time of writing).

The average new bond agreed with new residents by those homes taking bonds rose from an estimated $58,400 in the period 1997–99 to an estimated $188,798 in 2007–08.[17] [18] This represents an average, annual increase of more than 12 per cent in nominal dollars.

The maximum daily charge for accommodation for people entering high care is currently $21.39 per day for pensioners and $26.88 per day for non pensioners. People entering residential aged care generally undergo an assets test, which determines their level of assessable assets. For those with few assets (less than $91,410.40 at time of writing) the Commonwealth Government pays an accommodation subsidy on sliding scale up to $26.88 per day.

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[15] Aged care fees and charges change through the year, based upon indexation and changes to the aged pension. Information on aged care payments fees and charges in the following paragraphs is taken from the Department of Health and Ageing's website at www.health.gov.au and was current as at 15 December 2008.

[16] There is an exception to this: people entering 'extra service' high care can be asked to pay a bond, and virtually all of them do. Extra service places must offer a higher level of amenity, and the number of places that can be offered as extra service is limited to 5 per cent of all residential places.

[17] Department of Health and Aged Care (1999), Report on the Operation of the Aged Care Act 1997: 1 October 1997 to 20 June 1999 (Commonwealth of Australia: Canberra).

[18] Department of Health and Ageing (2008), Report on the Operation of the Aged Care Act 1997: 1 July 2007 to 30 June 2008 (Commonwealth of Australia: Canberra).

For Commonwealth community aged care packages there are no set fees or payments for living expenses or accommodation as these remain the responsibility of the person being cared for.[19] There are essentially only three levels of care payment in Commonwealth community care:

- $34.75 per day for a Community Aged Care Package;
- $116.16 per day for an Extended Aged Care at Home package; and
- $128.11 per day for an Extended Aged Care at Home – Dementia package

People can also be charged for community aged care packages. Older people on the maximum basic rate of pension can be charged up to 17.5 per cent of that pension – $6.78 per day at time of writing. People on higher incomes may be asked to pay additional fees up to 50% of any income they have above the maximum pension rate. The revenue from these charges goes to the provider, with no offsetting reduction in government subsidy.

6.4 Creating a better future

6.4.1 Funding people, not places

We have noted above that the Commonwealth currently limits the number of aged care places and also requires people to be assessed for eligibility to receive subsidised care. This can be likened to restricting the number of seats on buses (the number of aged care places), while also restricting the issuing of bus tickets (ACAT assessments of people's eligibility for Commonwealth-subsidised aged care).

We suggest that the number of aged care places should no longer be restricted ■

We suggest that the number of aged care places should no longer be restricted. This is not complete deregulation: providers of aged care would still need to meet existing criteria in order for the care they provide to be eligible for government support, including being an approved provider under the Aged Care Act and their facilities being accredited. However, if they meet these criteria, approved providers could offer as many places as they wished.

This would increase the chances that a person assessed by an Aged Care Assessment Team in hospital as eligible for aged care would be able to obtain a place in the home of their choice in a reasonable period.

However, in order to contain government spending on aged care, we are proposing that the number of people at any one time receiving subsidised aged care should be limited to the target ratio for provision. This would be done by Aged Care Assessment Teams having a maximum number of approvals for care that could be in effect at any one time for people living within an aged care planning region.

The maximum number of approvals would be calculated on the basis of a target ratio per 1000 older people in the same way as the current planning ratio for aged care places. Where the number of people assessed exceeds the approvals available, the assessments could provide a basis for assigning priority for the next available approval according to assessed need.

This change is equivalent to funding the 'people' needing access to an aged care service, rather than aged care services. Aged care providers would then have an incentive to compete for people assessed as needing aged care.

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[19] Some kinds of community support that replace living expenses, such as meals on wheels, often do involve some charge to the recipient.

We also note that the existing regulation involves an allocation of places on a geographic basis to promote equitable access to aged care services. Under our proposal to remove the regulation on the number of funded places, there may still be a need for regulatory or financial incentives to ensure there is not a flight of provision from the country to the city. Regulatory incentives might consist of a requirement to provide places in the country as well as the city in order to maintain approved provider status. Financial incentives might consist of little more than the existing viability supplements paid to rural and remote aged care providers. However, these may have to be adjusted to reflect the true additional cost of providing in rural and remote areas.

There is a second element of the existing regulation of aged care places that we believe is in need of review. The current benchmark for Commonwealth aged care provision is based upon the population aged 70 or over. The use of this population dates back some decades, when people had shorter life expectancies and entered residential care at earlier ages.

We are suggesting that the population aged 85 or over would be more appropriate, as it reflects the age of those who actually use Commonwealth aged care. 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 1000 people.[20]

Population projections from the Australian Bureau of Statistics indicate that, over much of the next decade, the population of people aged 85 or more will grow faster then the population of people aged 70 or more. If we continue to use a benchmarking planning ratio for aged care places based upon the population aged 70 or more, we will see a shortfall in the actual places that we need (see Figure 6.4).

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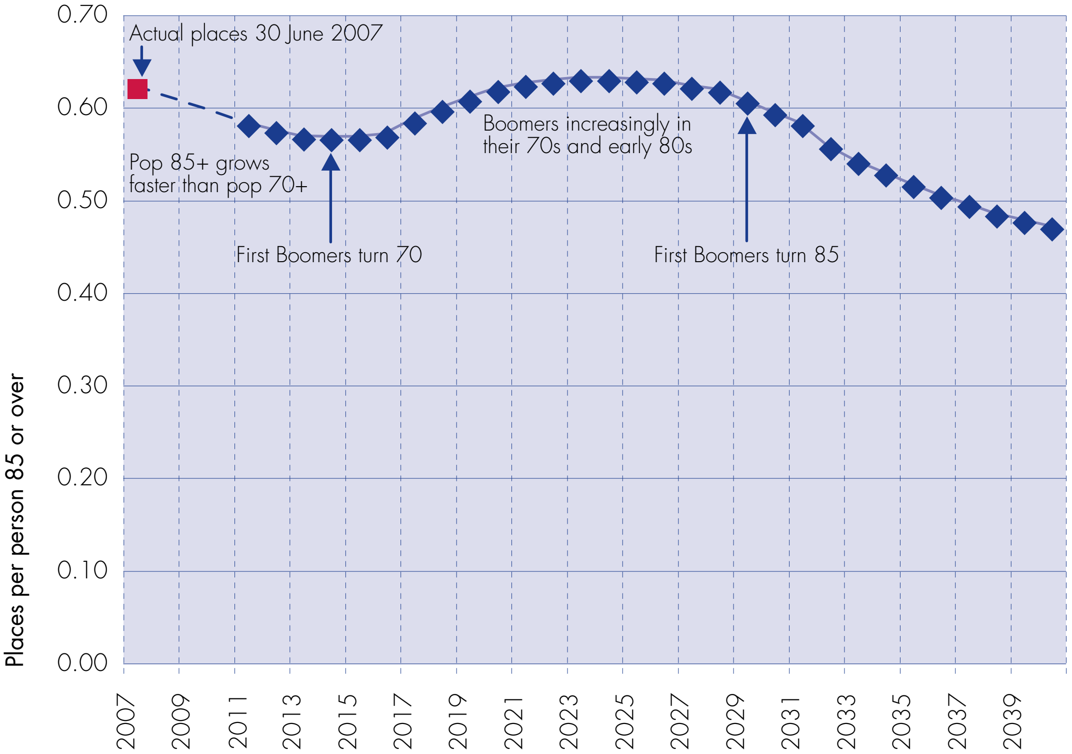
[20] The precise figure may need to be adjusted to reflect levels of occupancy. Further consideration is also required as to how best to allow for the younger ages at which Aboriginal and Torres Strait Islander people make use of aged care. At a minimum, the existing use of a ratio of 113 per 1000 Aboriginal and Torres Strait Islander people aged 50 or over should continue for this population.

Figure 6.4: Using the current planning ratio there will be fluctuations followed by a long-term decline in aged care places per person aged 85 or over.



Source: Australian Bureau of Statistics (2008), Population Projections Australia, series c and places ratio of 113 per 1000 people aged 70 or over

Reform direction 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**.

As noted earlier, the current restriction on the number of aged care places means charges must also be regulated to ensure that providers don't use their control over a scarce service to charge increased prices. Removing restrictions on the number of aged care places in line with reform direction 6.1 above should result in increased competition in the provision of aged care, which may extend to price competition. This may enable some cautious relaxation of current constraints on charges for residential care accommodation. There may need to be continued regulation of charges in areas (for example, rural areas) where there are too few providers for there to be a competitive market for provision.

Once again, we are not proposing complete deregulation. To ensure that people reliant on government subsidies are not disadvantaged in their access to care, existing requirements for aged care homes to have more than 40 per cent of all residents qualifying for a government accommodation payment (supported residents) should continue. In addition, consideration should be given to linking the level of government assistance for residential accommodation charges to, say, 80 per cent of the market average of the deregulated charge, so that homes catering disproportionately to the less well off do not lag too far behind in terms of the level of amenity they can provide.

We support the view that accommodation bonds in high care should be restricted in the existing circumstances of supply and regulation of aged care. However, if the current restrictions on the supply of aged care places are removed, as proposed in reform direction 6.1, and if the quest for residents demonstrably leads to sufficient competitive pressure on accommodation charges to bring growth in these into line with growth in general construction costs (not aged care specific construction costs), then it would seem reasonable to give new residents the option to pay an accommodation bond rather than an accommodation charge, if they wish.

Reform direction 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.

6.4.2 Informing choice

We note that it is difficult for older people and their families to find good information on the relative performance of aged care providers, upon which to base their choice of provider. To remedy this, we believe that the Commonwealth should require all aged care providers to publish standard measures of the quality of care and quality of life of the people for whom they provide care.

- It is difficult for older people and their families to find good information on the relative performance of aged care providers

Such measures should include information such as the number and kinds of direct care staff, measured in terms of average minutes per care recipient per day; measures of adverse events; care recipient satisfaction measures; and participation in recreational activities; to allow older people to make informed choices.

We note that a range of potentially useful indicators is set out in *Developing resident-centred quality indicators in residential aged care*, one of a number of reports developed in 2006 as part of ‘an evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes’.[21]

Reform direction 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.

6.4.3 Integrating aged care and enabling older people to have more control over their care

> *Many people found the information pathways, forms, and assessment processes for home care difficult to understand and confusing. People not yet getting services were uncertain how to find and get assistance.*[22]

We mentioned earlier some of the problems in ensuring continuity of care for older people moving from one kind of aged care service to another. If we look across the Home and Community Care (HACC) program, community aged care places (including Community Aged Care Packages and Extended Aged Care at Home Packages) and residential aged care services, there are a raft of different program rules that make the system complex for people and their families.

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[21] Developing resident-centred quality indicators in residential aged care, at: http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-iar-dev-residential-aged-care.htm+

[22] Council on the Ageing (2008), Consultations on in-home services for older people final report to Office for the Ageing (OFTA) for 2008–2011 home and community care triennial plan.

We believe that making HACC aged care a solely Commonwealth program would provide an opportunity to align the design and administration of HACC services for older people with Commonwealth community aged care.

This should include simplified assessment of eligibility for care, so that people can go through a single assessment process and be found eligible for HACC services, or for a Community Aged Care Package, or for Extended Aged Care at Home, and/or for residential aged care. This is not suggesting that someone who requires low-level assistance at home through HACC should be subject to a full ACAT assessment – rather, that there be a single graduated approach to assessment that takes the assessment only as far as is needed to identify the person's needs for care. For example, HACC providers might continue to assess people for HACC services, but using a common approach, and might refer people for ACAT assessment where it is apparent that higher levels of care are required.

Importantly for people, information obtained from one assessment would be passed on, with the client's consent, to any subsequent assessment to minimise the need to re-capture the same information again. Work towards this has been under way for some time. However, making HACC aged care a direct Commonwealth responsibility might enable it to be done more quickly.

Reform direction 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.

Reform direction 6.5

We propose developing and introducing streamlined, consistent assessment for eligibility for care across all aged care programs.

Funding for community aged care is not closely related to an assessment of a person's need for care

We noted earlier that funding for community aged care is not closely related to an assessment of a person's need for care. This concern was reinforced in the submission from the National Aged Care Alliance who observed that:

> *The current unit cost base funding model in community care promotes task centred care which has been demonstrated to promote dependency rather than independence. With the increased acceptance that we need to change the current service model within community care to one that more actively involves the client and promotes independence and well being, it becomes increasingly essential that the funding model be changed to one that is consistent with capacity building and independence promotion. Package funding allows for flexibility and matching the support to an individual's needs. Two package levels are, however, insufficient to cover the range of needs. A casemix funding model which has sufficient classes to describe the whole spectrum of needs across both community and residential care is required.* [23]

These views were echoed by Alzheimer's Australia:

> *Reform of the aged care system … should … restructure and reform community care so that care is available to respond to a range of needs, without inflexible program boundaries.* [24]

Currently, the Aged Care Funding Instrument (ACFI) is used to determine the level of government care subsidy for people entering residential aged care.

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[23] National Aged Care Alliance (2008), Submission 453 to the National Health and Hospitals Reform Commission.

[24] Alzheimer's Australia (2008), Submission 215 to the National Health and Hospitals Reform Commission.

We suggest that the ACFI should be further developed for use to determine the level of subsidy that should apply to a person receiving a community care package. This would ensure subsidies are provided in line with a more objective measure of need, and would also allow the care subsidies received by people in community care to be aligned with those in residential aged care.

Reform direction 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.

Existing funding and charging arrangements across aged care can create perverse incentives, so that people do not necessarily get the right care. The National Ex-Service Round Table on Aged Care argued that:

> *We have noted, for example, that some providers are 'packaging up' HACC and other services into forms of community care packages because clients are reluctant to pay the extra fee in moving to higher levels of care, which runs the danger of denying simple care services, because availability is monopolised. Our plea is for a seamless service which progresses through HACC (and DVA's Veterans Home Care scheme) to more complex care through CACPs, EACH and EACH-D, with a few going on to residential care.*[25]

A further distortion between current programs of aged care is the quite different user charging regimes that apply. As noted earlier, currently, providers of community care can charge full pensioners up to 17.5 per cent of their pensions, and people with higher incomes up to 50 per cent of any income they have above the maximum rate of pension. All charges go to the provider, and the government subsidy is undiminished.

These charges are steeper than the income-tested care fees that can be levied in residential care. Yet, full pensioners can ill afford to lose any part of their pension in care fees, while still having to meet their living expenses.

We believe that there is merit in aligning income-tested care fees for community aged care packages with those for residential care. The objective we want to achieve is to ensure that choices about different types of aged care are based more on need, rather than the costs or different charging arrangements.

■ There is merit in aligning income-tested care fees for community aged care packages with those for residential care

To illustrate this concept, this might mean that for people receiving community aged care packages the following would apply:

- no fees for full pensioners;
- a more moderate escalation of fees for people with higher incomes;
- limits to the maximum fee that could be charged; and
- a dollar for dollar reduction in the government subsidy, removing the current incentive for providers to maximise their charges as they retain 100 per cent, and yielding some savings to government.

We also know that there are quite different charging regimes for HACC services. HACC provides low levels of support to more than half a million older people. It would not be appropriate to institute the kinds of means assessment that currently apply to residential aged care to HACC recipients. However, a simpler approach, which would at least see full pensioners protected from charges for care services[26], could be considered.

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[25] National Ex-Service Round Table on Aged Care (2008), Submission 120 to the National Health and Hospitals Reform Commission.

[26] In this context, care services does not include services which meet ordinary costs of living, such as meals on wheels, for which a small out-of-pocket cost may still be appropriate.

Reform direction 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).

Existing funding arrangements for community aged care are not set up to support 'consumer-directed care', where people might choose the level and type of services they want to receive. Instead, funding is locked into 'packages' such as Community Aged Care Packages and EACH packages. The funding packages reflect 'average' levels of need, rather than actual levels of assessed need for the people receiving community aged care.

There would be more opportunity to move down the path of consumer-directed care

We have proposed in reform direction 6.6 that there be a more flexible range of care subsidies for people receiving community aged care. If this occurred, there would be more opportunity to move down the path of consumer-directed care. The level of resources available to people would be more closely related to an assessment of their need for care.

In addition, having an approach to assessment for care subsidy that is similar across community and residential care would provide a better basis for people to opt for community care rather than residential care. This might also enable a wider range of accommodation choices for people needing care, including, for example, through combining a budget allocation for consumer-directed community care with retirement village accommodation.

Reform direction 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.

Reform direction 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.

We noted earlier (and we discuss at more length in Chapter 7) issues related to the need to improve end of life care. It is apparent that many older people would prefer to have more say in the level of care they may receive, which is aimed at prolonging their life.

Reform direction 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.

6.4.4 Improving access to medical care in aged care

Some residents in aged care facilities do not currently get adequate access to primary health care, including primary medical care.

- Some residents in aged care facilities do not currently get adequate access to primary health care

We propose that funding be made available for aged care providers to strike arrangements with primary care providers (including general practitioners) and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes. Under such arrangements, residents would retain the right to be attended by, or to visit, their usual general practitioner, but would also have the option to see a visiting doctor during, say, a weekly 3.5 hour session on-site at the aged care home. These arrangements should also include establishment of an on-call roster between homes and general practitioners and geriatricians within a region. It seems more likely that general practitioners and geriatricians would make themselves available to be on-call if this were distributed among a larger number of practitioners, with fewer on-call periods per practitioner.

These arrangements might be struck between aged care homes and the proposed Comprehensive Primary Health Care Centres proposed in Chapter 2.

Reform direction 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.

6.4.5 Information to support care

An important part of 'connecting care' as people move between aged care, hospitals and primary health care is good information. In their submission, the National Ex-Service Round Table on Aged Care stressed the link between good information and quality of care for aged care residents:

> *Improvements in the quality of care could be made if a ready electronic communication system existed between hospitals and residential care, if patients had personal records that travelled with them, if there was some form of 'pay for results', i.e. hospitals were penalised for poor transfers, and/or if there was a discharge nurse who was responsible for managing this.* [27]

We believe that general practitioners attending residents of aged care homes would welcome an improved capacity to maintain common clinical records, electronically, in the aged care home and at their usual practice.

In Chapter 4 we have proposed that there be financial incentives for timely provision of discharge information by hospitals to a patient's nominated primary health care service. We believe the same incentives should apply to people living in residential aged care services, with timely provision of information by the hospital back to the aged care service.

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[27] National Ex-service Round Table on Aged Care (2008), Submission 120 to the National Health and Hospitals Reform Commission.

Reform direction 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

Key messages

- We face new challenges in providing end of life care. Some of these are related to changes in disease patterns (such as more people with dementia). Other challenges include ensuring that specialist palliative care services are available to all groups who would benefit from such care, and that these services are readily accessible in the community and in people's homes.
- Of the 130,000 people who die each year, many will be able to be supported prior to their death by generalist health professionals – their general practitioner or other primary health care professionals such as community nurses. Some will be managed by other specialists including geriatricians and oncologists.
- The direct support of specialist palliative care services is only needed for a relatively small number of dying people. Specialist palliative care support is sometimes only available at a relatively late stage, and some patients would benefit from earlier access to these services.
- There are some outstanding examples of high quality end of life care being provided by health services across Australia. We also have the benefit of a National Palliative Care Strategy and good outcomes data that can be used by health professionals to improve the experience of supporting people who are dying, together with their families and carers.
- There is good evidence that advance care planning can help people have choice and more control over their dying, with their wishes respected about how and where they die.

Our reform directions

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.

A 'good death' is something we all want for ourselves and our loved ones

Death comes to all of us. This is a time when we and our families look to our health services, particularly for care and support. A 'good death' is something we all want for ourselves and our loved ones. We heard this view many times. We heard it in our face-to-face meetings with the community and health professionals. We read about these concerns in the hundreds of written submissions sent to us. The many voices and sentiments are captured in the words of one palliative care physician who wrote to us on the value of high quality care at the end of life:

> *It is very important that our health system provides not only good specialist palliative care services, but a high standard of care for everyone being cared for in the terminal phase of their illness, regardless of whether this is in hospital, residential care or the community. When being admitted to an Australian specialist hospital for a heart transplant, or for coronary artery bypass grafts, a patient can have absolute confidence in the care they will receive during these very complex and technical procedures. Our patients should be able to have the same level of faith and confidence in the care that they will receive when it is their time to die – and the incidence of this condition is one hundred per cent.*[1]

7.1 Defining and scoping end of life care

End of life care is care provided to people who are living with a condition that will ultimately cause or contribute to their death. For some people, there may be a relatively short and acute period of illness before they die, as occurs with some patients who have cancer or have suffered a severe stroke. Some people may have chronic health problems such as diabetes or kidney disease, or live with other disabling conditions such as multiple sclerosis or dementia for many years. For yet other people, death may be sudden and unexpected, whether arising from injury or violence. And, of course, death can come at any age, so our approach to end of life care needs to be able to respond to the different timings and ways in which people die.

Of the approximately 130,000 deaths each year in Australia, at least 100,000 could be considered to be expected.[2] While most deaths occur in people aged 65 or above, 25.1 per cent of men and 15.2 per cent of women die in what has traditionally been regarded as their 'working years' – before turning 65.[3] The death of children and young people, whether expected or unexpected, represents a heavy burden on families and will usually require support from health services.

We agree with the views of Palliative Care Australia that end of life care can be provided by all health professionals – including general practitioners, other primary health care professionals such as community nurses, and specialists such as geriatricians and oncologists – and is not limited to care provided by palliative care services or specialists.

To put it another way, many of the 130,000 deaths each year will not require direct support from specialist palliative care services. These specialist services involve multi-disciplinary health care teams made up of staff with recognised qualifications or accreditation in palliative care, whose main work is supporting people at the end of life. The Australian and New Zealand Society of Palliative Medicine recognises that it is 'neither feasible nor in fact desirable that all dying patients should be managed by specialist palliative care services'.[4]

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[1] B Hayes (2008), Submission 235 to the National Health and Hospitals Reform Commission.

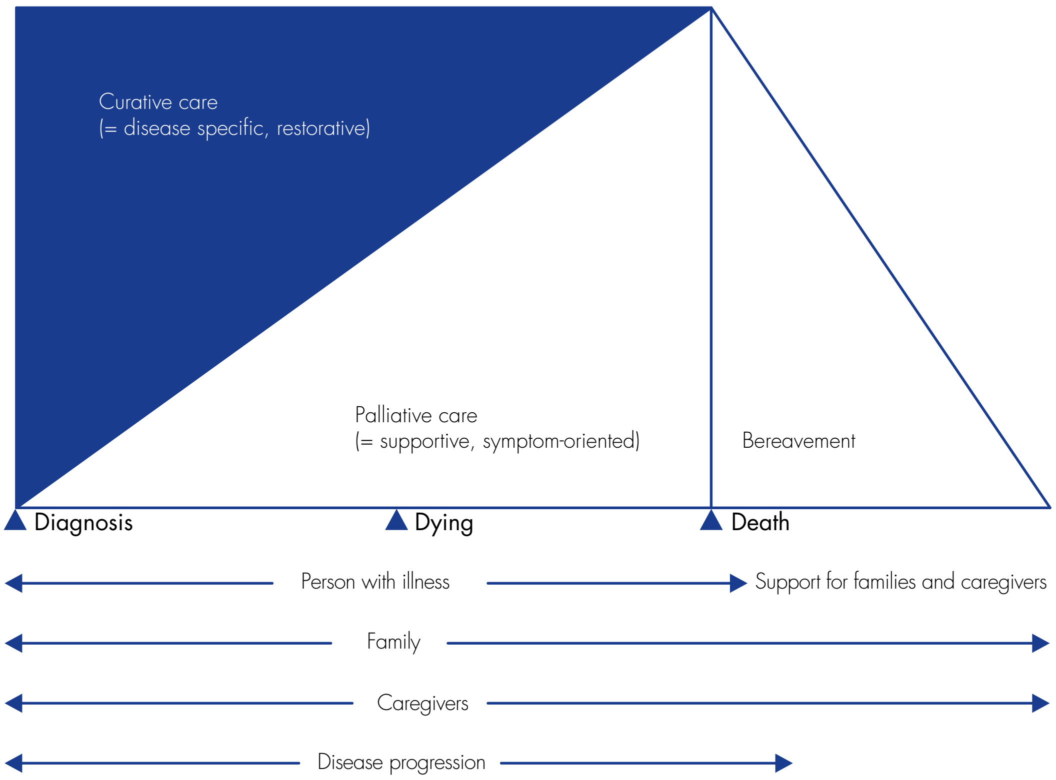
[2] Palliative Care Australia (2008), Submission 142 to the National Health and Hospital Reform Commission.

[3] Australian Institute of Health and Welfare (2008), Mortality FAQs – Data on age and sex distribution of death in 2006, at: http://www.aihw.gov.au/mortality/data/faqs.cfm.

[4] Australian and New Zealand Society of Palliative Medicine (2008), Submission 430 to the National Health and Hospitals Reform Commission.

For the sub-group of dying people who would benefit from specialist palliative care services, these services can be the sole or dominant source of health and supportive care, or they can act as a back-up and consultation support to other health professionals. Specialist palliative care services may also be provided at the same time as ongoing curative treatment such as radiotherapy for cancer. This changing pattern of end of life care recognises that the actual time of death is unpredictable and that palliative support may be beneficial as a terminal condition progresses (Figure 7.1).

Figure 7.1: Palliative care may start well before dying and extends to support for families and carers after a death



Source: Australian and New Zealand Society of Palliative Medicine (2008), Submission 430 to the National Health and Hospitals Reform Commission.

7.2 Building on our strengths

There is much that is positive about the state of play for end of life care in Australia.

A National Palliative Care Strategy has been in place since 2000. Importantly, this strategy is not simply words on paper. It has received some funding support through investment under the National Palliative Care Program, including dedicated funding under the current 2003–2008 Australian Health Care Agreements.

National funding has also been used to drive quality improvement in palliative care. This is vital and ties in well with our principle that health services must be part of a learning system, continuously seeking to improve and innovate through sharing effective practices and measuring improvement through robust data on outcomes. This focus on quality improvement can provide a template for other areas of health service delivery.

■ National funding has also been used to drive quality improvement in palliative care

Two of the most significant initiatives are:

- The Palliative Care Outcomes Collaboration (the Collaboration) allows all providers of palliative care services (public and private) to submit data that supports national benchmarking of performance.[5] The Collaboration is funded by the Commonwealth Government and involves four universities who then link to palliative service providers across Australia. Data collected through the Collaboration measures the health and functioning status of patients receiving palliative care services. Information provided back to palliative care services can be used to support clinicians in treatment decisions. It also allows assessment of how services are tracking against the nationally agreed Standards for *Providing Quality Palliative Care for All Australians.*[6]
- The CareSearch Palliative Care Knowledge Network at Flinders University provides an incredibly rich resource tailored to the needs of patients, families and clinicians seeking evidence-based information related to palliative care.[7] This one-stop shop covers everything from finding locally accessible palliative care services to systematic reviews of the literature to providing tutorials on how to find and interpret evidence for patients and health professionals. Shared responsibility requires a well-informed community and this resource on palliative care provides one model of an initiative that supports our reform direction of improving health literacy identified in Chapter 1.

Moving from the national to the local level, palliative care providers have developed better ways of organising services that are more people- and family-centred with services available closer to home, as shown in Figures 7.2 and 7.3.

Figure 7.2: Silver Chain is bringing palliative care to West Australians in their homes

Silver Chain is a not-for-profit organisation that has been providing community, residential and health services to the Western Australian community for over 100 years. It is funded by the state government with other funding sources including a mix of community donations, Medicare and Department of Veterans' Affairs payments and direct payments from patients.

In 1982, Silver Chain developed their Metropolitan Hospice Care Service which is one of the largest community-based palliative care services in Australia. It comprises teams of registered nurses, doctors, enrolled nurses, care aides, counsellors, chaplains and trained volunteers, with a case coordinator planning the delivery of care. Patients are also able to access in-home respite services, counselling and bereavement support. Professional support is provided through 24-hour access to telephone-based Nurse Consultancy Services to provide specialist nursing advice, assessment and procedures to meet the needs of individual patients.

This comprehensive palliative care program supports about 550 palliative care patients at any one time in the community. It substitutes for at least half that number of inpatient hospital beds. The extended availability of this service, together with strong clinical governance, has made it the standard model of care for people who prefer to die at home. Silver Chain estimates that this program has contributed to higher rates of people dying at home – about 60 per cent in Perth, compared to about 25 to 30 per cent in the rest of Australia.

Source: Based on communication from C McGowan, CEO of Silver Chain to the NHHRC, May 2008. Further information is available at: http://www.silverchain.org.au/Services/Palliative-Care

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[5] Further information on the Palliative Care Outcomes Collaboration is available at: http://chsd.uow.edu.au/pcoc/about_pcoc.html

[6] Palliative Care Australia (2005), Standards for providing quality palliative care for all Australians, at: http://chsd.uow.edu.au/pcoc/documents/standards_palliative_care.pdf

[7] Further information on the CareSearch Knowledge Network is available at: http://www.caresearch.com.au/caresearch/Home/tabid/80/Default.aspx

Figure 7.3: Link nurses are helping to improve palliative care for Adelaide people living in residential aged care facilities

Commencing in 1999, a Commonwealth and state government funded project provided an education and consultancy service to 49 residential aged care services in Adelaide. 'Link nurses' were nominated to lead the delivery of palliative care in their residential aged care facility, supported through educational workshops and seminars provided by specialist palliative care service providers. A published evaluation revealed that staff were more confident and had better knowledge and skills when caring for dying residents. This initiative has subsequently been implemented in other parts of the country, including the Northern Territory and Queensland.

Link nurses in Adelaide are passionate about the benefits of this approach for their patients.

> *As our involvement with the Link Nurse Group grew, so did the enthusiasm for 'doing this so much better'. With support from the group we successfully applied for a grant from the Department of Health & Ageing which allowed us to develop a dedicated Palliative Care suite, Reflection room and purchase equipment for home use. We identified gaps not only in our personal knowledge, but also in the systems and processes within the health unit and which were already in place to provide good palliative care for our patients and residents.*
>
> *In order to address these gaps we have researched and developed a number of palliative care specific tools such as assessment forms, care plans, family charts, and have also adopted the Palliative Care Clinical Pathways and Bereavement Resource Folders, which were developed within the Link Nurse Group, for use within our health unit.*
>
> *The introduction of these tools has created a wider awareness and interest in palliative care among nursing, care and medical staff. This has had a 'ripple' effect which has resulted in a number of our aged care residents now having Advance Directives or a Good Palliative Care Plan in place, the implementation of a Bereavement Support Program, education for all staff around palliative care issues and the commencement of the National Palliative Care Standards Implementation Project which will support and expand the care we currently give to palliative patients and their families.*[4]

Source: C Grbich, I Maddocks, D Parker and colleagues (2008), Presentation: Palliative care in aged care facilities for residents with non-cancer diagnoses, at: http://www.pallcare.asn.au/pdf/presentation_pdf/P008.pdf

7.3 Identifying the case for change

We received submissions from the palliative care workforce, service provider and professional associations, and consumer and disability organisations that highlighted some major areas where reform is needed.

7.3.1 Improving access to effective palliative care

Specialist palliative care services largely emerged to meet the needs of one group of dying patients, people with cancer. Many other groups remain less well-served by palliative care services today. For example:

The number of patients with dementia is expected to more than triple from 220,000 in 2007 to 730,000 in 2050

- Alzheimer's Australia has identified particular challenges in managing end of life care for people with dementia including communication difficulties, managing adequate nutrition and hydration, and ensuring that pain does not go unrecognised and under-treated.[8] The number of patients with dementia is expected to more than triple from 220,000 in 2007 to 730,000 in 2050.[9]
- Palliative care services may not be targeted towards younger people with degenerative conditions. There are about 1300 people in Australia with motor neurone disease with an average age of onset of 59 years and an average life expectancy from prognosis of 28 months. Motor Neurone Disease Australia argues that palliative care is relevant from diagnosis onwards 'to provide expert symptom management and psychosocial support for the person with motor neurone disease and their families'.[10]
- Generally, non-cancer patients are much less likely to receive access to palliative care services. A recent study in Western Australia of over 25,000 deaths found that two-thirds (68 per cent) of people dying of cancer received specialist palliative care services, but less than one in ten (8 per cent) of people with selected non-cancer conditions were able to access the same services.[11]
- For Aboriginal and Torres Strait Islander peoples, palliative care services may not be provided in a culturally appropriate way (such as including 'smoking ceremonies' at the time of death). However, the Northern Territory Palliative Care Service has achieved real improvements, with an 85 per cent rate of 'back to home country' visits for dying patients.[12]

7.3.2 Providing more choice in where people die and access to palliative care in all settings

We suggested in *Beyond the Blame Game* that a benchmark might be set to measure the number of emergency department visits and hospital days in the last 30 days of life. Our argument then was that higher rates of use of hospital services may signify a failure in the provision of home-based palliative care.

This concept seemed to be broadly endorsed in many of the submissions we received. The Australian and New Zealand Society of Palliative Medicine (the Society) advised that higher rates of home deaths in Western Australia probably reflect the well established community-based palliative services provided in that state[13] (see Figure 7.2).

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[8] Alzheimer's Australia (2006), Palliative care and dementia, at: http://www.alzheimers.org.au/upload/PalliativeCare.pdf

[9] Access Economics (2005), Dementia estimates and projections: Australian states and territories, Report prepared for Alzheimer's Australia, at: http://www.alzheimers.org.au/content.cfm?infopageid=1926

[10] Motor Neurone Disease Australia (2008), Submission 114 to the National Health and Hospitals Reform Commission.

[11] L Rosenwax and B McNamara (2006), 'Who receives specialist palliative care in Western Australia – and who misses out', Palliative Medicine, 20: 439–445.

[12] Quality Care at the End of Life Collaborative Stakeholders (2008), Submission 504 to the National Health and Hospitals Reform Commission.

[13] Australian and New Zealand Society of Palliative Medicine (2008), Submission 430 to the National Health and Hospitals Reform Commission.

The Society cautions against assuming that all deaths should be at home, noting that social and cultural factors make this unrealistic, but that instead the emphasis should be on 'informed choice' for where people die. This is known as 'dying-in-place', a concept that we support and accordingly have included in our amended principle on comprehensiveness.

Some of the barriers that were identified[14] to people receiving end of life care in their home (including people living in a residential aged care service) included:

- workforce shortages that limit access to quality multidisciplinary care at home, with gaps in access to specialist palliative care practitioners in many settings;
- limited access to general practitioners and other primary health care providers to provide pain relief, especially in residential aged care services;
- carer fatigue and lack of access to respite for carers; and
- reluctance by some private health insurers to funding non-hospital based palliative care options, coupled with a lack of access to palliative care services in many private hospitals.

The lack of access to palliative care across all settings means that people may be transferred from their home to hospital when they are dying. For people and their families, the unfamiliar environment, the lack of continuity and the need to navigate and work with a new set of health care professionals compounds what is already an incredibly difficult situation. The Australian and New Zealand Society of Palliative Medicine argues that the need to provide seamless integrated care is perhaps 'the single most important reform required to improve end of life care for all Australians'.[15] We believe that poor communication and integration should be tackled throughout our health system, and especially for vulnerable groups such as dying patients and their families.

7.3.3 Supporting consumer control through better use of advance care planning

One effective approach to tackling problems in communication and continuity for dying patients is the use of advance care planning. These plans are about helping to ensure that people's wishes about how and where they die are respected, not about helping people to die earlier. There is compelling evidence that the use of advance care plans can help people to die in the setting of their choice and to exert greater control over the types of care they receive when they are dying.

■ There is compelling evidence that the use of advance care plans can help people to die in the setting of their choice

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[14] Quality Care at the End of Life Collaborative Stakeholders (2008), Submission 504 to the National Health and Hospitals Reform Commission.

[15] Australian and New Zealand Society of Palliative Medicine (2008), Submission 430 to the National Health and Hospitals Reform Commission.

Figure 7.4: Patients and health professionals support the use of advance care plans

Clinicians involved in implementing the Respecting Patient Choices program in different settings (residential aged care facilities, hospitals and general practice) contributed case studies to us on the positive impact of using advance care plans. Two of these stories follow:

> *Mr Jones suffered from chronic obstructive pulmonary disease, epilepsy and dementia. As he was unable to articulate his own concerns, his family clearly stated their preference should his symptoms warrant urgent attention: 'He's absolutely terrified of hospital. We'd hate him to be sent off alone by ambulance in the middle of the night.' A family conference was arranged in consultation with the local medical officer and advice was received from the regional palliative consultant, who had particular expertise in managing respiratory crises. A step-by-step plan was formulated and shown to the family. The plan proved effective on several occasions when Mr Jones suffered distressing symptoms of dyspnoea [shortness of breath]. An appropriate plan was also developed for his epilepsy. When he suffered a major seizure, the crisis was managed in the aged care facility. Both the family and the aged care team expressed satisfaction that his symptom control could be managed well by the nurses, that he had a well-formulated care plan, and that he was spared a distressing and disorienting hospitalisation.*

> *Thank you so much for your excellent documentation which accompanied Mrs A last night. We agreed with her 'directive' that all possible measures be taken to exclude any reversible cause of her health crisis and that, if nothing further could be done, then her preference would be to return to the nursing home to be cared for by her 'second family'. She has suffered a massive brain stem stroke and we recommend she be returned to your care and given the benefit of palliative care. Your clear documentation helped us resolve a difficult ethical decision.*

Source: W Silvester and colleagues (2008), Submission 18 to the National Health and Hospitals Reform Commission.

Up to 50 per cent of people will not be in a position to make their own decisions as they near the time of their death[16], with some people having significant cognitive impairment due to conditions such as dementia or a stroke and other people having major physical impairments. The evaluation of the Respecting Patient Choices Program (a model of advance care planning initially implemented across 17 residential aged care services and two palliative care services) found that advance care plans were important in promoting 'dying in place'. It found that 85 per cent of people with an advance care plan received end of life care in their residential aged care facility, while 67 per cent of people without an advance care plan were transferred from their residential aged care facility and died in hospital.[17] Research has also shown that most people expect health professionals to initiate discussions on advance care plans, while only 2.3 per cent of residents in aged care facilities approached about advance care plans wanted no further discussion on the issue.[18]

However, we heard through both our submissions and our listening tour that advance care plans are not widely used. Some of the barriers to greater use of advance care plans include the lack of national leadership, confusion about differences in the legislative framework across states and territories, and the lack of support for workforce training on the use of advance care plans.

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[16] Australian and New Zealand Society of Palliative Medicine (2008), Submission 430 to the National Health and Hospitals Reform Commission.

[17] Australian and New Zealand Society of Palliative Medicine (2008), Submission 430 to the National Health and Hospitals Reform Commission.

[18] Australian and New Zealand Society of Palliative Medicine (2008), Submission 430 to the National Health and Hospitals Reform Commission.

7.4 Creating a better future

We believe that there is a need to improve access to palliative care services. We see this issue having several dimensions.

First, we want to emphasise the vital role of primary health care services in providing a palliative approach in the care of dying patients. Clearly, 'end of life care is everyone's affair'[19], not just the job of specialist palliative care services. We believe that this will require greater educational support for general practitioners and other primary health care professionals in how to better manage dying patients. We also expect that this will require improved integration between specialist and primary health care services involved in supporting dying patients. Other specialists, such as geriatricians, often have a very important role in caring for dying patients and their families. Specialist health care teams involved in the long-term care of some patients (such as those with cystic fibrosis) also need to focus on the early, appropriate introduction of a palliative approach.

Dying is a part of life. Our primary health care services, particularly general practitioners, already provide most care to dying patients. This may include coordinating the provision of clinical support services such as community nurses and other personal support services (such as help with showering) for people at home. We have stressed throughout this report that primary health care must be the foundation of our future health care system. This means that specialist palliative care services need to integrate more closely with primary health care professionals and provide more outreach so that the capacity of primary health care services to support dying patients is expanded.

- Dying is a part of life. Our primary health care services, particularly general practitioners, already provide most care to dying patients

Reform direction 7.1

We propose building the capacity and competence of primary health care services, including the Comprehensive Primary Health Care Centres, 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.

Second, we understand that there is likely to be a shortfall in the overall provision of specialist palliative care services. Palliative Care Australia has proposed that the recommended referral rate to palliative care services should be 262 people per 100,000 population, while the current referral rate is somewhere between 111 and 198 per 100,000 population.[20] However, we note that these are high-level national estimates and there is a lack of data about shortfalls in palliative care services at a state or local level and what are the precise service and workforce gaps. We would welcome any advice and further data that can be used to assess the size of the unmet need for access to specialist palliative care services more systematically at a national and local level.

Third, we are strongly of the view that access to specialist palliative care services should be made easier across all settings. Most specialist palliative care services are based in public hospitals and funded directly by state governments (with funding sourced from both the state and Commonwealth governments). We are very aware that under existing governance and funding arrangements these services may be viewed as being 'owned by' or 'owed to' public hospital patients. Where it exists, this view must change. We must unshackle 'services' from their existing institutional homes, or indeed their self-made prisons! It is patently nonsensical that specialist palliative care services are not readily available to people living in residential aged care facilities, on the basis that these services and facilities are funded by different levels of government. The same holds true for patients in other settings including private hospitals.

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[19] Palliative Care Australia (2008), Submission 142 to the National Health and Hospital Reform Commission.

[20] Palliative Care Australia (2003), Palliative care service provision in Australia: A planning guide, at: http://www.palliativecare.org.au/Portals/46/resources/PalliativeCareServiceProvision.pdf

Reform direction 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.

The achievement of this reform direction requires that once we have better data on the current distribution and gaps in access to specialist palliative care services, we begin setting benchmarks for access to these services, including in residential aged care services. We note that the Commonwealth Government has previously released guidelines on implementing a palliative care approach in residential aged care facilities and that Palliative Care Australia is developing training resources to support staff in these facilities.[21]

We endorse the collaborative models of outreach and support that have been developed between some hospitals and residential aged care facilities. While local cooperation is laudable, we are conscious that it is all too easy at a systemic level for governments and agencies to revert to the 'blame game', and claim that they are 'not responsible' for ensuring access to appropriate palliative care for aged care residents as they are not 'funded' for this service. We are pleased to note that changes to the Aged Care Funding Instrument being phased in from 2008 to 2011 will result in higher payments for people with complex health needs (including potentially palliative care for dying patients) living in residential aged care facilities. In our next report, we will consider if other systemic changes (including funding levers, benchmarks etc.) are necessary to give effect to the reform direction of strengthening access to palliative care for this population group.

Fourth, we believe that palliative care services need to be more accessible on an ambulatory basis (that is, for patients who are not admitted to a hospital) and provided to people in their homes in the community. Silver Chain provided data to us[22] on their success in operating a community-based palliative care service. We find these data compelling (see Figure 7.5). Of about 3000 patients under the care of Silver Chain in the three year period from January 2005 to December 2007, 961 patients (32 per cent) were able to be cared for solely at home during the last 40 days of their life. This is a wonderful example of a people- and family-centred health service. While this is our overriding objective, this approach also helps meet our principle of a health system that is focused on 'value for money'. The average cost of community-only care for a dying patient over the last 40 days of their life was $4600. This compares with an average cost of just under $18,000 for people who spent the last 40 days of their life in a hospital. If this experience was translated to a national level, the potential savings from smarter investment are substantial.

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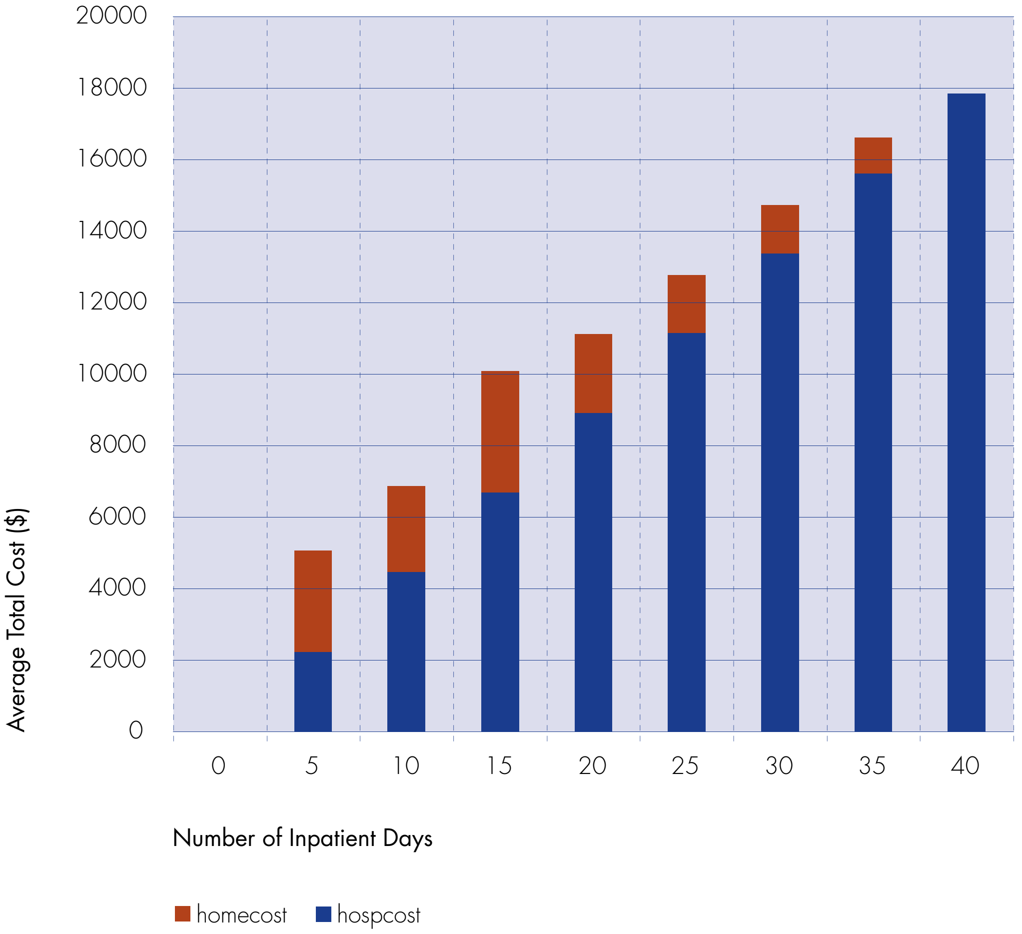
[21] The Guidelines for a Palliative Approach in Residential Aged Care, at: http://www.agedcare.palliativecare.org.au

[22] Information provided by C McGowan, CEO of Silver Chain, October 2008: Hospice Care Service Model.

Figure 7.5: Community-based palliative care is more cost-effective than only providing palliative care in hospitals



Source: Information provided by C McGowan, CEO of Silver Chain, October 2008: Hospice Care Service Model

Note: The chart shows the costs of providing palliative care to patients who differ according to how much of their care is provided in the home or in a hospital. The left-hand side of the graph presents the costs for patients who receive the last 40 days of their care at home. The right-hand side of the graph presents the costs for patients who receive the last 40 days of their care in a hospital.

Reform direction 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.

We turn now to the issue of advance care planning.

Once again, we find that the evidence[23] in support of action on advance care planning, and more specifically the Respecting Patient Choices model, is strong and cannot be ignored:

- The evidence in support of action on advance care planning, and more specifically the Respecting Patient Choices model, is strong

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[23] Austin Health (2008) Submission 534 to the National Health and Hospitals Reform Commission

- 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; but
- residents in aged care facilities who were not 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 dying.

On the basis that there are about 41,000 deaths each year of people living in residential aged care services, the national implementation of Respecting Patient Choices in all aged care facilities could result in 237,800 fewer hospital bed days used each year. In round terms, this is equivalent to a saving of about $250 million annually.

The decision by the Commonwealth Government to fund the piloting and evaluation of the Respecting Patient Choices program in Australia has laid the groundwork for our proposals on these issues. (As a general comment, health professionals across Australia told us they wanted a health system that moved beyond the dreaded disease of 'pilotitis' – endless cycles of pilot projects – to investing in systemic reforms. In Chapter 13, we present some views on how to promote smarter investment.)

Reform direction 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.

We understand that national implementation of this program across all aged care facilities would generate a strongly positive return on investment, compared to the $250 million annual costs of hospital admissions avoided for this group. However, we also note that there may need to be a shift in the provision of palliative care resourcing from hospitals to residential aged care services to accommodate the higher needs of more people dying in these facilities.

Ultimately, the implementation of advance care planning is about honouring the wishes of patients and their families. The guiding principle of the Respecting Patient Choices program is:

> *If your choices for future health care are known, they can be respected.*[24]

We noted in Figure 7.1 that a palliative approach to care can co-exist with curative treatment for some patients. In line with this situation, we believe it is important that people have early access to information on advance care planning. People need good information about the likely course of their illness, as early as possible, so that they can plan and make decisions about their future use of health care services.

National implementation of advance care planning requires national leadership. We believe that there will be a need to establish a national peak body[25] to promote the development and implementation of advance care planning. Among other functions, this agency should:

- lead a national social marketing and communication strategy to promote awareness about the use of advance care plans. Effective communication and information is vital for many groups – the general community, people who are dying and their families and carers, and health professionals.

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[24] Austin Health (2008) Submission 534 to the National Health and Hospitals Reform Commission.

[25] Further information on Respecting Patient Choices is available at: http://www.respectingpatientchoices.org.au

- ensure that advance care planning is systemically embedded in accreditation and benchmarking processes. We note, for example, that Austin Health (as the current home of the Respecting Patient Choices program) has been collaborating with the Aged Care Standards and Accreditation Agency to develop guidelines on how advance care plans can assist in meeting accreditation criteria.
- work with other organisations – including government, private providers and funders, professional bodies, consumer and carer groups – to promote the adoption of advance care planning across all settings. This would include general practice, public and private hospitals, and residential aged care services. For example, we understand that the Royal Australian College of General Practitioners, with the support of the Respecting Patient Choices program, will shortly roll out an online general practitioner education module on advance care planning.
- collaborate with universities and professional associations to promote the inclusion of advance care planning in all undergraduate programs.

A final issue relates to the differences across states and territories in the legislation relating to end of life decisions and advance care planning.[26] Some states have no supporting legislation. In states which have legislated on this issue, there are differences in the approach used on issues such as whether a witness is required; whether substitute decision-makers can be used; and whether advance care plans can only be made for patients with a terminal illness. We understand that some health professionals are concerned that these interstate differences may impede continuity and appropriate implementation of advance care plans for people who receive care outside their home state. We have been advised that Attorneys-General across Australia are undertaking work on harmonising relevant aspects of existing state legislation on end of life decisions and advance care planning.

Reform direction 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.

In forming this view, we are cognisant of the fact that legislation is neither necessary nor sufficient to change the cultural practice and adoption of advance care planning. The successful implementation of the Respecting Patient Choices program was driven not by legislation, but by a strong focus on training to equip health professionals to work with patients and their families, and attention to organisational and cultural change. Accordingly, we support working with health care professionals to promote better understanding of the existing common law right on medical decision-making.

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[26] W Silvester and colleagues (2008), Submission 18 to the National Health and Hospitals Reform Commission.

FACING INEQUITIES

RECOGNISE AND TACKLE THE CAUSES AND IMPACTS OF HEALTH INEQUITIES

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

Key messages

- Aboriginal and Torres Strait Islander people have poor health, which is reflected in high levels of morbidity and life expectancy 17 years lower than other Australians. Closing this gap is a national priority and responsibility.
- A whole of government commitment is required to address the social determinants of health, as well as improving health services. In particular, it is estimated that health service provision can potentially contribute up to 70 per cent to closing the gap.
- Most Aboriginal and Torres Strait Islander people (75 per cent) live in larger cities and regional towns. Aboriginal and Torres Strait Islander people access health services across the delivery spectrum – for example, general practitioners, hospitals, rehabilitation, drug and alcohol, aged care, mental health and maternal and child health, as well as comprehensive community-controlled health services. These need to be culturally sensitive, responsive and focused on achieving the best possible outcomes.
- There is significant potential to reduce the gap across the life span:
    - a healthy start, maternal and child health;
    - quality care with a particular focus on critical transition times, such as infant to childhood, to adolescence, to workforce entry, to parenthood, to older years; and
    - chronic disease is estimated to account for around 70 per cent of mortality, much of which would be responsive to action on targeting risk factors at the system, community, family and individual levels.
- Aboriginal and Torres Strait Islander people are under-serviced; therefore, greater investment is needed to reach the under-served to ensure access to appropriate and responsive care, to drive good practice, quality improvement, and the achievement of better outcomes, and to influence action on the social determinants that affect health outcomes. Greater investment is likely to flush out unmet need and result in higher recorded levels of morbidity in the first instance.
- Aboriginal Community Controlled Health Services play an important role in the delivery of comprehensive primary health care, maximising people's potential and ameliorating illness as a barrier to Aboriginal and Torres Strait Islander people's participation in family, community and workforce. These Services need to be enabled to deliver services in an efficient manner.
- The number of Aboriginal and Torres Strait Islander people in health profession training and the number of health professionals trained in Aboriginal and Torres Strait Islander health need to be addressed.

Our reform directions

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.

Aboriginal and Torres Strait Islander peoples of Australia are the oldest continuing cultures in human history.

Under the leadership of the Prime Minister, and with full support of the states and territories, significant and comprehensive work has been undertaken to identify strategies to close the life expectancy gap. This report builds on that work and identifies key strategies to maximise the health sector's contribution.

Aboriginal and Torres Strait Islander peoples make up 2.5 per cent of the Australian population, just over half a million people.[1] Yet, they experience far greater social, economic and educational disadvantage compared to other Australians. This disadvantage is associated with poor health and increased exposure to health risk factors.

Overcoming this disadvantage is achievable. Public awareness of the issues facing Aboriginal and Torres Strait Islander people is at an all time high, and the impetus for action is strong.

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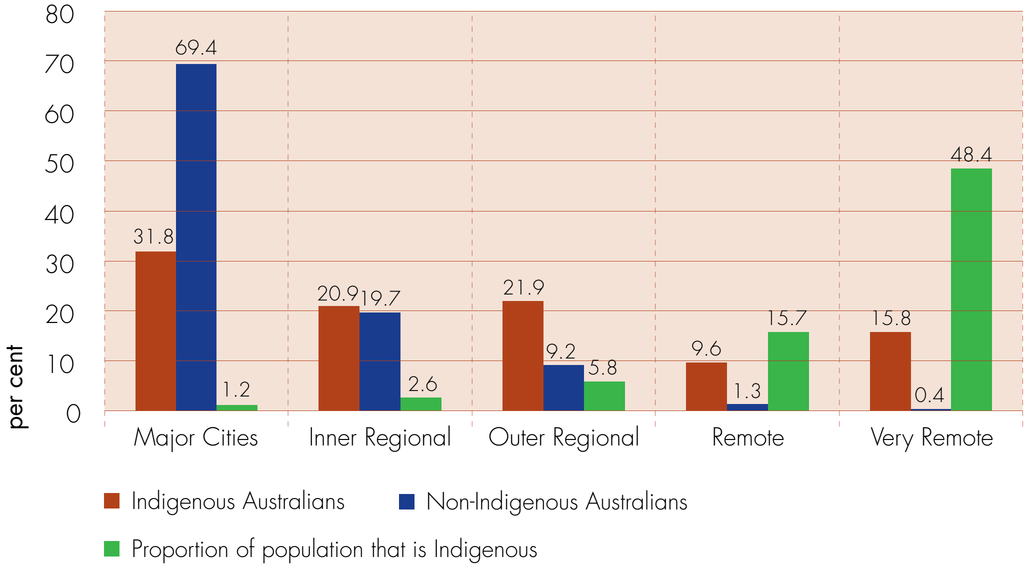
[1] Australian Institute of Health and Welfare (2008), Australia's health 2008 (Australian Institute of Health and Welfare: Canberra).

8.1 Defining and scoping the health status of Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people have poorer health compared to other Australians, and poor Aboriginal and Torres Strait Islander health drives much of the difference in health status between the cities and rural Australia. Australia's Indigenous population has much poorer health than Indigenous populations in comparable countries (Canada, United States, New Zealand).[2]

Most Aboriginal and Torres Strait Islander people live in a major city or regional centre[3], but the Aboriginal and Torres Strait Islander proportion of the total population increases with geographic remoteness, from one per cent of the total population living in major cities to 48 per cent living in very remote areas (see Figure 8.1).

Figure 8.1: Most Aboriginal and Torres Strait Islander people live in major cities or regional centres but they make up a larger share of the population in remote areas



Source: Australian Bureau of Statistics (2008), Population Characteristics, Aboriginal and Torres Strait Islander Australians, 2006 (Australian Bureau of Statistics: Canberra)

Overall, Aboriginal and Torres Strait Islander people are a young population with 57 per cent aged less than 25 years compared with 33 per cent of other Australians; and only three per cent aged 65 years and over compared with 13 per cent of other Australians.

Aboriginal and Torres Strait Islander people have a higher burden of disease, higher mortality at younger ages, and a life expectancy 17 years lower than for other Australians[4]:

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[2] I Ring and J O'Brien (2007), 'Our hearts and minds – what would it take for Australia to become the healthiest country in the world?', Medical Journal of Australia 187 (8): 447–451.

[3] Australian Bureau of Statistics (2008), Population Characteristics, Aboriginal and Torres Strait Islander Australians, 2006 (Australian Bureau of Statistics: Canberra).

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

- The burden of disease and injury is estimated to be 95,976 years of life lost through premature death or living with disability[5] – two and a half times greater than the burden of disease carried by other Australians despite the Aboriginal and Torres Strait Islander population being a young population.
- Aboriginal and Torres Strait Islander men are three times as likely to die before they reach 60 years old compared to other Australian men (32 per cent compared to 10 per cent), while Aboriginal and Torres Strait Islander women are four times as likely to die before 60 years old compared to other Australian women (23 per cent compared to six per cent).[6]
- Aboriginal and Torres Strait Islander children are three times as likely to die before they reach 15 years old compared to other Australian children.[7]
- Life expectancy at birth for Aboriginal and Torres Strait Islander people for the period 1999 to 2001 was 59 years for males and 65 years for females, 17 years lower than other Australians.[8]

Aboriginal and Torres Strait Islander children are three times as likely to die before they reach 15 years old compared to other Australian children

When asked to consider their own health status[9], almost one-quarter (22 per cent) of Aboriginal and Torres Strait Islander people reported their health as fair or poor; this is twice as high as other Australians. Almost two-thirds (65 per cent) reported at least one long-term health condition, with a high proportion also reporting stressors experienced by themselves, family or friends. For example:

- Stressors were reported by 81 per cent of those with kidney disease, 75 per cent of those with diabetes, 74 per cent of those with asthma and 75 per cent of those with arthritis.[10]
- By far the most commonly reported stressor was the death of a family member or close friend, followed by alcohol and drug problems. Other stressors included overcrowding at home, abuse or violent crime, gambling problems and unemployment.[11]

Chronic illness is a major issue and is estimated to account for around 70 per cent of the life expectancy gap between Aboriginal and Torres Strait Islander people and other Australians.[12] Cardiovascular disease (17 per cent) and mental disorders (15 per cent) are the leading causes of disease burden (see Figure 8.2). It has been calculated that 11 modifiable risk factors, including alcohol, drug and tobacco use, physical inactivity, low fruit and vegetable intake, and high blood cholesterol account for 37 per cent of the burden of disease and for around 50 per cent of the health gap carried by Aboriginal and Torres Strait Islander Australians. Substance use, food security, and activity are all amenable to change with good support strategies and services.

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[5] T Vos, B Barker, L Stanley and A Lopez (2007), The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples (School of Population Health, The University of Queensland: Brisbane).

[6] T Vos, B Barker, L Stanley and A Lopez (2007), The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples (School of Population Health, The University of Queensland: Brisbane).

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

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

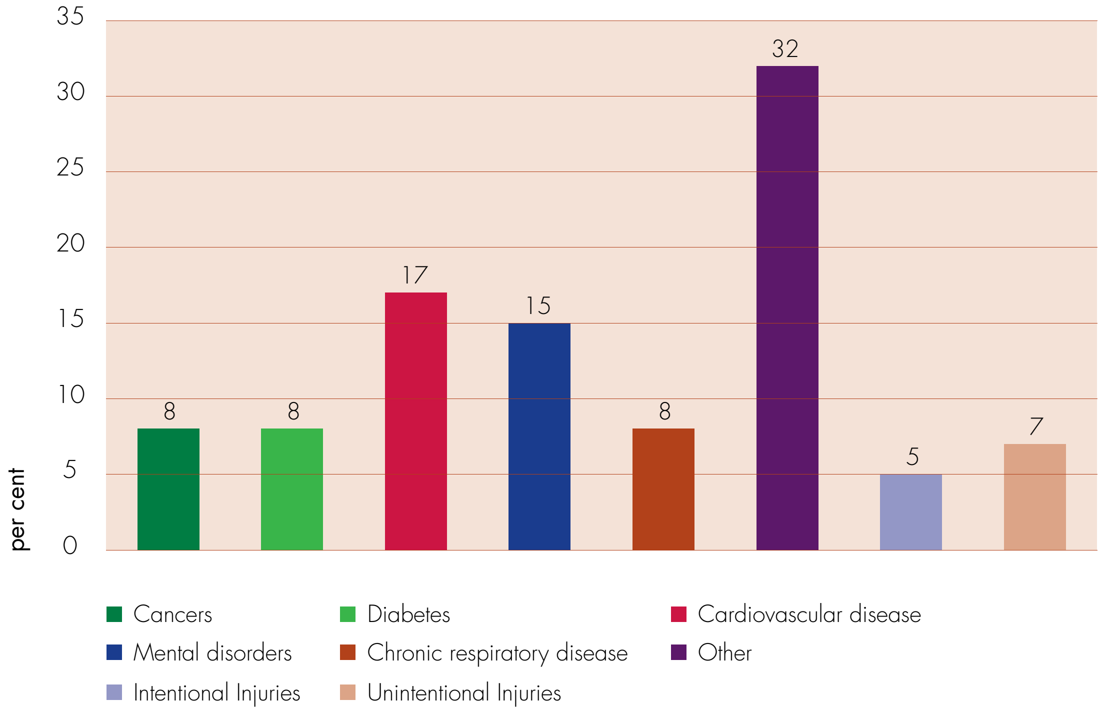
[9] Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008 (Australian Institute of Health and Welfare: Canberra).

[10] Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008 (Australian Institute of Health and Welfare: Canberra).

[11] Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008 (Australian Institute of Health and Welfare: Canberra).

[12] T Vos, B Barker, L Stanley and A Lopez (2007), The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples (School of Population Health, The University of Queensland: Brisbane).

Figure 8.2: Cardiovascular disease and mental disorders are the two leading contributors to the disease burden of Aboriginal and Torres Strait Islander Australians



Source: T Vos, B Barker, L Stanley and A Lopez (2007), The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples (School of Population Health, The University of Queensland: Brisbane).

On a more positive note, some improvements have been made in health status. Available data from Queensland, Western Australian, South Australia and the Northern Territory show that: all-cause mortality decreased by 16 per cent between 1991 and 2003; infant mortality declined by 44 per cent, and perinatal mortality by around 55 per cent; and sudden infant death syndrome declined by 60 per cent over the period 1997–99 to 2000–03.

8.2 Building on our strengths

Much work has been done by Aboriginal and Torres Strait Islander people, health professionals and researchers to educate and advocate for positive strategies to address the inequities faced by Aboriginal and Torres Strait Islander people and their communities, backed up by numerous reports, strategies and reporting mechanisms. Some key activities are described below.

The National Aboriginal Health Strategy (NAHS), developed in 1989, was a landmark document providing agreed directions for Aboriginal and Torres Strait Islander health policy in Australia.[13] Key priorities included building community control of Aboriginal health services, increasing Aboriginal and Torres Strait Islander participation in the health workforce, and increasing funding to Aboriginal and Torres Strait Islander health services.

An evaluation of the NAHS in 1994 found that it had not been implemented due to underfunding by all governments. This led to the development of the National Strategic Framework for Aboriginal and Torres Strait Islander Health, endorsed by the Commonwealth and state and territory

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[13] Agreements, treaties and negotiated settlements project, at: www.atns.net.au

governments in 2003. The goal of this framework is to ensure that Aboriginal and Torres Strait Islander people enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice.[14] 'Importantly, it commits government to the monitoring and implementation of efforts towards improvements in Aboriginal people's heath'.[15]

The 2005 Social Justice Report, *Achieving Aboriginal and Torres Strait Islander health equality within a generation – A human rights approach*, set out a 'human rights framework for achieving health equality within a generation' and led to the Close the Gap Campaign for Indigenous Health Equality. This work has culminated in Commonwealth and state and territory government commitment to action, supported by the Australian community.

The Council of Australian Governments (COAG) in December 2007 agreed to 'a partnership between all levels of government to work with Indigenous communities to achieve the target of closing the gap on Indigenous disadvantage'[16] in relation to health inequality as well as education and employment.

This commitment was reaffirmed by the Prime Minister in the *National Apology to Australia's Indigenous Peoples* on 13 February 2008 and formalised with the signing of the *Statement of Intent* in March 2008:

> *Our challenge for the future is to embrace a new partnership between Indigenous and non-Indigenous Australians. The core of this partnership for the future is closing the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities. This new partnership on closing the gap will set concrete targets for the future: within a decade to halve the widening gap in literacy, numeracy and employment outcomes and opportunities for Indigenous children, within a decade to halve the appalling gap in infant mortality rates between Indigenous and non-Indigenous children, and within a generation, to close the equally appalling 17 year-life gap between Indigenous and non-Indigenous when it comes to overall life expectancy.*[17]

The National Indigenous Health Equity Council has been established to 'provide national leadership in responding to the Government's commitment to closing the gap on Indigenous disadvantage by providing advice to Government on working towards the provision of equitable and sustainable health outcomes for Indigenous Australians'.[18]

On 30 November 2008, COAG announced $4 billion in funding to 'improve housing, health, employment and to drive fundamental reforms to Indigenous service delivery over the next ten years'[19], of which $1.6 billion is for the National Partnership on health service reform. The National Partnership is expected to contribute to: a reduction of smoking rates among Aboriginal and Torres Strait Islander peoples; a reduction in the burden of disease among Aboriginal and Torres Strait Islander peoples; an increase in the uptake of Medicare Benefits Schedule-funded primary care services to Aboriginal and Torres Strait Islander people, where half of the Aboriginal and Torres Strait Islander adult population (ages 15–65 years) will receive two adult health checks over the next four years; an improvement in coordination across the continuum of care; and a reduction in the average length of hospital stay and readmissions (over time).[20]

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[14] National Strategic Framework for Aboriginal and Torres Strait Islander Health (2008), at: www.health.gov.au

[15] S Couzos and R Murray (2008), Aboriginal Primary Health Care: An evidence-based approach (Oxford University Press: Oxford).

[16] Council of Australian Government Meeting Outcomes (2 December 2007), at: www.coag.gov.au

[17] Prime Minister of Australia (2008), Apology to Australia's Indigenous Peoples, House of Representatives, Parliament house, Canberra.

[18] National Indigenous Health Equality Council Terms of Reference, at: http://www.nihec.gov.au/internet/nihec/publishing.nsf/Content/terms

[19] Prime Minister and Minister for Families, Housing, Community Services and Indigenous Affairs, Media Release, Canberra 30 November, at: http://www.pm.gov.au/media/Release/2008/media_release_0674.cfm

[20] Council of Australian Governments, Council of Australian Governments meeting communiqué, 29 November 2008, Parliament House, Canberra.

At a program level, a wide range of policy approaches has been implemented or trialled to improve Aboriginal and Torres Strait Islander access to health services and health outcomes. Many of these activities have made significant gains from which policy makers can draw lessons.

The Pharmaceutical Benefits Scheme Section 100 arrangements, which enable eligible services in remote areas to supply PBS medication free of charge and without a prescription, have greatly improved access to medications for Aboriginal and Torres Strait Islander people living in these areas.[21]

The Audit for Best Practice in Chronic Disease (ABCD) is a continuous quality improvement approach to improving chronic disease detection and management in Aboriginal primary health care services, and is described in Figure 8.3.

Figure 8.3: The ABCD approach

The ABCD works with health professionals, centres and services to improve the delivery of care using a structured and collaborative approach to review the systems that support care such as recall, clinical guidelines, and cycles of care to assess clinical performance against best practice guidelines.

The evaluation report found that, over the first three years of the program, participating health centres improved their levels of evidence-based care, and interim health outcomes also improved:

> *After two cycles of the CQI intervention, 12 participating Aboriginal community health centres have maintained their active engagement in the project and achieved impressive improvements in a number of key indicators of the quality of chronic illness care.*

Key findings and lessons include:

- *scheduled diabetes services delivered increased from 31 per cent to 54 per cent;*
- *improvement in the proportion of people with diabetes with a record of a blood pressure check within three months from 63 per cent at baseline to 78 per cent;*
- *improvement in the proportion of people with diabetes with a record of an HbA1c check within six months from 41 per cent at base line to 75 per cent;*
- *improvement in the proportion of people with diabetes whose most recent HbA1c check was < 7 per cent from 19 per cent at baseline to 28 per cent;*
- *improvement in the proportion of people with diabetes whose most recent total cholesterol was < 4 mmo1/L from 22 per cent at baseline to 30 per cent;*
- *some key indicators of diabetes care such as blood pressure control did not show improvement;*
- *the delivery of preventive services to the general adult population show relatively little improvement;*
- *health centre staff and management indicate an important factor in the success of the project has been the participatory approach;*
- *the availability of resources and the quality of management and organisational systems are important in driving improvements in quality of care; and*
- *best practice medical management and self-management support needs to be strengthened to ensure early diagnosis and good monitoring result in improved health outcomes.*

Source: Audit and Best Practice for Chronic Disease Project Progress Report prepared for Department of Health and Ageing: Health for Life, November 2005

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[21] Urbis Keys Young, Aboriginal and Torres Strait Islander Access to Major Health Programs: Final Report July 2006, at: http://www.medicareaustralia.gov.au/public/services/indigenous/files/aboriginal_torres_strait_islander_access_to_major_health_programs.pdf

The Specialist Outreach Service (SOS) in the Northern Territory also works well. This program was set up in response to 'problems of access for remote community people, mostly Aboriginal, to surgical, obstetric and gynaecological specialists, and subsequently to ophthalmic and ENT (ear, nose and throat) specialist care.'[22] The program resulted in a total of 3647 consultations and procedures in remote community clinics between June 1997 and September 1999, with up to five times more specialist consultations taking place than previously, when patients were transferred to Darwin hospital. This region also has regular paediatric and physician outreach embedded in the primary health care regional outreach team.

Aboriginal Community Controlled Health Services have contributed significantly to reductions in communicable disease, improved detection and management of chronic disease, and better child and maternal health outcomes, including reductions in preterm births and increases in birth weight.[23] Reasons for their success include the delivery of culturally appropriate comprehensive primary health care, including population health programs, as well as other services such as facilitating access to secondary and tertiary care, transport, social and emotional wellbeing and family support.

The Nganampa Health Council is one example where gains have been made in the areas of child and maternal health and the control of sexually transmitted diseases (see Figure 8.4).

Figure 8.4: Targeting maternal and child health makes a difference

The Nganampa Health Council has been operating on the Anangu Pitjantjatjara Yankunytjatjara Lands in the northwest of South Australia since the mid 1980s. The catchment area for the Nganampa Health Council is approximately 105,000 square kilometres.

When first established, the Nganampa Health Council identified that women were not having regular antenatal visits or check-ups, and were often not presenting at a clinic until late in their second trimester. They set targets to improve antenatal care:

- *ensuring first presentation is made before 20 weeks;*
- *having more than five antenatal visits per pregnancy; and*
- *performance of ultrasounds in all pregnancies – this includes ultrasounds for estimating gestational age.*

Results show that, between 1993 and 1999, women accessing antenatal care for the first time less than 20 weeks into their pregnancy had increased from 60 per cent, to around 90 per cent. Furthermore, data indicated a decrease in perinatal mortality rates and decreases in low birth weights.

The Nganampa Health Council has also implemented a strategy for dealing with sexually transmitted infections through a program of screening 12–40 year olds. Through this, the prevalence of syphilis that requires treatment has been reduced from 20 per cent in 1985 to less than one per cent in 2000. Further, the prevalence of gonorrhoea and chlamydia has been reduced by 62 per cent and 56 per cent respectively.

Source: Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians (2001) (Commonwealth of Australia).

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[22] R Gruen and R Bailie (2000), Evaluation of the Specialist Outreach Service in the Top End of the Northern Territory, at: www.menzies.edu.au

[23] J Dwyer, K Silburn and G Wilson (2004), National Strategies for Improving Indigenous Health and health Care, Aboriginal and Torres Strait Islander Review: Consultant Report No. 1 (Commonwealth of Australia).

8.3 Identifying the case for change

8.3.1 Closing the life expectancy gap

Closing the gap by 2030 is a national priority. It requires a whole of government commitment to addressing the social determinants of health and improving health services across the care continuum and life course.

- Closing the gap by 2030 is a national priority. It requires a whole of government commitment to addressing the social determinants of health and improving health services across the care continuum and life course

Aboriginal and Torres Strait Islander people experience far greater social disadvantage than other Australians in terms of education, housing, and employment, and this, in turn, has a direct impact on health. This was emphasised in our national consultations and in submissions:

> *High levels of disadvantage in many Indigenous communities in terms of income, education and infrastructure continue to exert a strong negative effect on health.*[24]
>
> *To improve health outcomes in Northern Territory and to close the gap between Indigenous and non-Indigenous health outcomes and the remote areas will rely on other portfolios and funding streams, to improve housing, education, transport, recreation etc. Health outcomes and socio-economic status are closely related.* [25]

In 2001, the average income of Aboriginal and Torres Strait Islander families was 62 per cent of the mean for other Australian families – $364 per week compared with $585 per week for other families. Using the national distribution of income 'quintiles', 72 per cent of Aboriginal and Torres Strait Islander households were in the two lowest income quintiles, compared with 39 per cent for other Australians. This directly impacts on Aboriginal and Torres Strait Islander people's capacity to pay for health services as well as clothing, housing and food – all directly related to health.

The relationship between health and social determinants such as employment, education and housing works both ways. For example, higher levels of education may lead to people engaging in positive health behaviour (for example, exercising, regular health check ups) while poor health may lead to low educational attainment as people are unable to attend school.[26] In 2004–05, Aboriginal and Torres Strait Islander adults who had completed Year 12 compared with adults who had left school in Year 9 or below were: more likely to report excellent or very good self-assessed health; less likely to report high or very high levels of psychological distress; and less likely to smoke regularly.

This link between health and social determinants emphasises the importance of cross-sectoral action. Estimates on the contribution of how much health services and other determinants contribute to the health gap suggest that socio-economic factors account for between 30 and 50 per cent.[27] The balance is thought to be 'driven by access to health services (health supply driven), health behaviour (patient driven), environmental factors, or a combination of all of these'.[28] The Australian Indigenous Doctors' Association summarises that:

> *Australian governments must work together to improve outcomes on issues such as education, employment, housing and environmental health.*[29]

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[24] Cooperative Research Centre for Aboriginal Health (2008), Submission 527 to the National Health and Hospitals Reform Commission.

[25] Northern Territory Dept of Health and Families (2008), Submission 520 to the National Health and Hospitals Reform Commission.

[26] Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008 (Australian Institute of Health and Welfare: Canberra).

[27] A Booth and N Carroll (2005), The Health Status of Indigenous and Non-Indigenous Australians, Discussion Paper No. 486 (Centre for Economic Policy Research).

[28] A Booth and N Carroll (2005), The Health Status of Indigenous and Non-Indigenous Australians, Discussion Paper No. 486, (Centre for Economic Policy Research).

[29] Australian Indigenous Doctors Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

By taking a life course approach targeting health and socio-economic risk factors, as outlined in earlier chapters, there is significant potential within the health system to reduce the gap. It has been estimated that 50 per cent of the health gap carried by Aboriginal and Torres Strait Islander Australians is attributable to risk factors that could be modified (see Figure 8.5).[30] The Queensland Aboriginal and Islander Health Council emphasises that:

> *Most of the diseases leading to premature death, hospitalisation and chronic disability amongst Aboriginal and Torres Strait Islander people are preventable if diagnosed early. Indeed, most of the general health gains that have been made in recent years can largely be attributed to initiatives in the primary health care sector such as childhood vaccination programs, disease-specific screening programs and antenatal programs*[31]

Positive parenting practices and experiences will impact on child development and subsequent academic attainment, and health and wellbeing ■

As outlined in Chapter 3, the early years provide the foundations for a person's health and wellbeing in life – good maternal health pre-conception is important for reducing the risk of low birth weight babies, who are prone to ill health in childhood, and may also be more prone or 'programmed' to chronic disease in adulthood. Currently, low birth weight is twice as common for Aboriginal and Torres Strait Islander babies.[32] Significant health improvements for mothers, babies and future adults can be gained by tackling the high smoking rates in pregnant women (around half of Aboriginal and Torres Strait Islander women smoke during pregnancy), and other risk factors such as alcohol consumption and healthy eating. Similarly, positive parenting practices and experiences will impact on child development and subsequent academic attainment, and health and wellbeing.

Adolescents, people moving from schools to work, people becoming parents and families, and older people will also face a range of risks and challenges that if addressed sooner rather than later will have a positive impact on their immediate and long-term health and wellbeing.

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[30] T Vos, B Barker, L Stanley and A Lopez (2007), The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples (School of Population Health, The University of Queensland: Brisbane).

[31] Queensland Aboriginal and Islander Health Council (2008), Submission 483 to the National Health and Hospitals Reform Commission.

[32] Australian Health Ministers' Advisory Council (2006), Aboriginal and Torres Strait Islander Health Performance Framework, AHMAC, Canberra.

Figure 8.5: Indigenous burden and health gap is attributable to 11 risk factors

	Disease burden		*Health gap*	
	DALYs	*% of total*	*DALYs*	*% of total*
Total burden	***95,976***	***100***	***56,455***	***100***
Attributable burden				
Tobacco	*11,633*	*12*	*9,816*	*17*
Obesity	*10,919*	*11*	*8,953*	*16*
Physical inactivity	*8,032*	*8*	*6,554*	*12*
High blood cholesterol	*5,262*	*5*	*3,994*	*7*
Alcohol	*5,171*	*5*	*2,362*	*4*
High blood pressure	*4,417*	*5*	*3,215*	*6*
Low fruit & vegetable intake	*3,344*	*3*	*2,873*	*5*
Illicit drugs	*3,264*	*3*	*2,150*	*4*
Intimate-partner violence	*2,469*	*3*	*1,836*	*3*
Child sexual abuse	*1,390*	*1*	*869*	*2*
Unsafe sex	*1,174*	*1*	*926*	*2*
11 risk factors combined	***35,908***	***37***	***27,383***	***49***

Source: T Vos, B Barker, L Stanley and A Lopez (2007), The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples (School of Population Health, The University of Queensland: Brisbane).

Note: DALY = Disability Adjusted Life Year

Importantly, Aboriginal and Torres Strait Islander people who live in cities and regional centres suffer almost the same health gap as those who live in remote communities. Improving Aboriginal and Torres Strait Islander health is not just an issue for remote communities, it is an issue for every community: city, rural and remote. We need to enhance both mainstream and Aboriginal and Torres Strait Islander specific health services to improve access to, and the impact of, primary health care and linkages with services across the delivery spectrum. It is about making absolutely sure that services, including hospitals, in all communities are effective and accessible.

- Improving Aboriginal and Torres Strait Islander health is not just an issue for remote communities, it is an issue for every community: city, rural and remote

8.3.2 Investing in Aboriginal and Torres Strait Islander health care

We were told at the national consultations and in submissions that health care services for Aboriginal and Torres Strait Islander people are under-resourced. This means the focus tends to be on providing reactive and emergency services with little capacity to provide the full range of services needed to provide early diagnosis, clinical intervention, prevention and promotion activities to address health risk and life opportunity factors.

> *The challenge for Indigenous health will be to integrate preventative programs while at the same time addressing an excess of acute and chronic morbidity, including co-morbidities. Aboriginal and Torres Strait Islander primary health care services are often overwhelmed by the curative demand and the sector is chronically under resourced. It is important therefore that effective preventative programs can be implemented while at the same time the existing burden of disease is addressed.*[33]

Funding is from multiple sources, with tight rules for what it could be spent on, affording little scope for flexibility; and neither holistic nor necessarily reflecting local needs or local priorities. For example, 26 funding streams resulted in 26 separate accounts and 26 demands for accountability for the Danila Dilba Aboriginal Medical Centre in Darwin.[34] Some funding is also short-term which creates problems in terms of sustainability of outcomes and continuity of care.[35] We were also told:

> *Stop the body parts funding – the system is meant to look after people, not a kidney*[36].

In 2004–05, estimated total health expenditure for Aboriginal and Torres Strait Islander people was $2,304 million or 2.8 per cent of the total health expenditure. On a per person basis, average expenditure was $4718 – 17 per cent higher than expenditure for other Australians ($4019).

Aboriginal and Torres Strait Islander Australians carry a higher burden of illness and, like all other Australians, those whose health is compromised require, and should receive, more care accordingly

- But this funding is not equitable because, on average, Aboriginal and Torres Strait Islander Australians carry a higher burden of illness and, like all other Australians, those whose health is compromised require, and should receive, more care accordingly.

Studies undertaken on the level of investment needed to improve health outcomes and reduce the life expectancy gap for Aboriginal and Torres Strait Islander peoples all conclude that significantly higher levels of expenditure are required. Estimates of the funding required range from doubling all government health expenditure, to increasing all health expenditure per capita on Aboriginal and Torres Strait Islander people to a bit over twice the average for the rest of the population, to increasing per capita health expenditure to three to six times the level for the rest of the population.[37,38,39,40,41,42]

The importance of adequate investment is further highlighted in a study by Beaver and Zhao[43] (see Figure 8.6).

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[33] Australian Indigenous Doctors Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

[34] B Henty, S Houston and G Mooney (2004), 'Institutional Racism in Australian healthcare: a plea for decency', Medical Journal of Australia 180 (10): 517–520.

[35] C Shannon and H Longbottom (2004), Capacity Development in Aboriginal and Torres Strait Islander Health Service Delivery – Case Studies, Aboriginal and Torres Strait Islander Primary Heath Care Review: Consultant Report No. 4 (Commonwealth of Australia).

[36] Health professional (3 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Darwin.

[37] G Mooney (2000), 'What's fair in funding indigenous health care? We don't know, but isn't it time we did?', the Drawing Board: An Australian Review of Public Affairs 1 (2): 75–85.

[38] J Deeble, How much is needed? A needs based funding formula for Aboriginal and Torres Strait Islander health, cited in AMA Public Report Card 2002, Aboriginal and Torres Strait Islander Health: No more excuses, at: http://www.ama.com.au/node/3188

[39] Econotech Pty Ltd (2004), Costings Models for Aboriginal and Torres Strait Islander Health Services, Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No. 3 (Commonwealth of Australia).

[40] Australian Medical Association (2008), Institutionalised inequity. Not just a matter of money, 2007 Report Card, at: www.ama.com.au/web.nsf/doc/WEEN-7EVGV

[41] Queensland Aboriginal and Torres Strait Islander Health Council (2008), Submission 483 to the National Health and Hospitals Reform Commission.

[42] J Dwyer, K Silburn and G Wilson (2004), National Strategies for Improving Indigenous Health and Health Care, Aboriginal and Torres Strait Islander Review: Consultant Report No. 1 (Commonwealth of Australia).

[43] C Beaver and Y Zhao (2004), Investment analysis of the Aboriginal and Torres Strait Islander Primary Health Care Program in the Northern Territory, Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No. 2 (Commonwealth of Australia).

Figure 8.6: Adequate health care funding is important

In 2003, Carol Beaver and Yuejen Zhao undertook an investment analysis of the Aboriginal and Torres Strait Islander primary care program in the Northern Territory. They tested five investment scenarios using nine categories of preventable diseases: hypertension, diabetes, renal diseases, ischaemic heart disease, chronic obstructive pulmonary disease, respiratory and related ear infections, diarrhoea, malnutrition, and skin infection.

The study showed that:

- *changing the funding mix by shifting $1 million from clinical primary health care to heath promotion and prevention would result in a gain of 14,000 disability adjusted life years in five years but this benefit would be offset by the loss of 18,600 disability adjusted life years as a result of shifting resources away from diagnosis, treatment and continuing care for chronic diseases;*
- *withdrawal of primary care funding would lead to a loss of 2.6, 6.1 and 12.6 years per Aboriginal and Torres Strait Islander person in 5, 10 and 20 years time; and*
- *a staged increase in funding in primary health care across the continuum of health promotion, prevention and clinical care rising to double the 2001–02 levels over a period of ten years would increase life expectancy by three years per person in five years, 5.7 years per person in ten years, and 9.9 years per person in 20 years.*

Beaver and Zhao also assessed the potential impact of achieving higher engagement from other sectors. Analysis shows that it might be possible to increase the benefits of primary health interventions by around 35 per cent if services can be delivered in a way that more effectively meets the needs of people at the local level and enables people to take greater responsibility for their own health.

Source: C Beaver and Y Zhao (2004), Investment analysis of the Aboriginal and Torres Strait Islander Primary Health Care Program in the Northern Territory, Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No 2 (Commonwealth of Australia)

8.3.3 Building a health system to meet the needs of Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people access health services across the delivery spectrum. Barriers to accessing health services across the delivery spectrum, including those provided by mainstream and Aboriginal Community Controlled Health Services, need to be addressed if we are to build a health system that meets the needs of all Aboriginal and Torres Strait Islander people and translates into better outcomes.

Around 30 per cent of Aboriginal and Torres Strait Islander people report that their usual source of care is an Aboriginal medical service, while around 60 per cent said that a doctor was their usual source.[44] For Aboriginal and Torres Strait Islander people living in very remote regions, an Aboriginal medical service is the usual source of care.

Expenditure provides some insight into health service use. Figure 8.7 shows that Aboriginal and Torres Strait Islander people tend to be high users of public hospitals, patient transport services, and community health services, and comparatively low users of medical, pharmaceutical and other health services compared with other Australians.

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[44] Australian Health Ministers' Advisory Council (2006), Aboriginal and Torres Strait Islander Health Performance Framework 2006 report, AHMAC, Canberra.

Figure 8.7: Aboriginal and Torres Strait Islander people are low users of privately-provided services and high users of publicly provided services

	Indigenous	*Non-Indigenous*	*Ratio (a)*
Hospitals	*2213*	*1386*	*1.6*
Public hospital services (b)	*2147*	*1067*	*2.0*
• Admitted patient services	1637	1067	2.0
• Non-admitted patient services	510	244	2.1
Private hospitals	*66*	*319*	*0.2*
High-level residential care	*85*	*319*	*0.3*
Patient transport	*212*	*69*	*3.1*
Medical services	*337*	*734*	*0.5*
Community health services	*1019*	*155*	*6.6*
Dental and other health practitioners	*160*	*396*	*0.4*
Medications	*224*	*561*	*0.4*
Aids and appliances	*38*	*131*	*0.3*
Public health	*182*	*68*	*2.7*
Research	*94*	*85*	*1.1*
Health administration	*153*	*114*	*1.3*
Total	***4718***	***4019***	***1.2***

(a) Average per person expenditure on Indigenous Australians divided by the average per person expenditure on other Australians

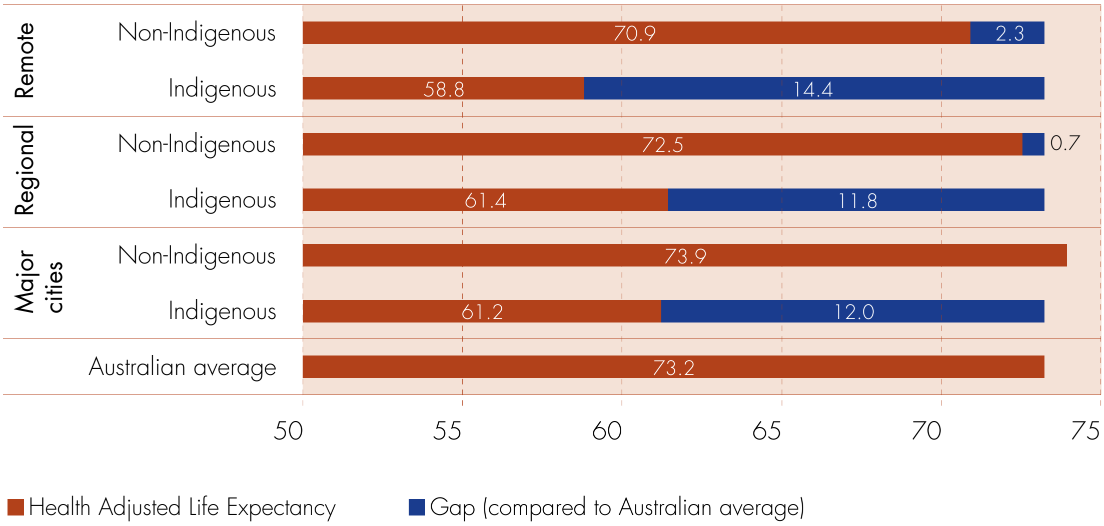
(b) Excludes any dental services, community health services, public health and health research undertaken by the hospital

Source: Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008 (Australian Institute of Health and Welfare: Canberra).

Aboriginality is a stronger predictor of life expectancy than place of residence

Where you live has a strong influence on whether services are available but, for Aboriginal people, Aboriginality is a stronger predictor of life expectancy than place of residence (see Figure 8.8). The number of years an Aboriginal and Torres Strait Islander person can expect to live without a disability ranges from 58.8 years (if living in a remote centre) to 61.4 years (if living in a regional centre) to 61.2 years (if living in a major city). This is between 11.8 years and 14.4 years below the Australian average of 73.2 years. As most Aboriginal and Torres Strait Islander people live in cities and regional centres, and as the expectancy gap is almost the same between city and remote populations, it is misleading to think of improving Aboriginal and Torres Strait Islander health as solely an issue of addressing problems in remote Aboriginal and Torres Strait Islander communities.

Figure 8.8: The health gap for Aboriginal and Torres Strait Islander people does not differ greatly across geographic locations



Source: Personal communication with S Begg, School of Population Health, University of Queenslan

While well documented, barriers to access range from (but are not limited to) cultural and social factors; to geographic; to financial; to poor linkages; to a lack of population focus; to workforce.

Generally, the health system delivers services in a way that is better suited to the needs of the broader population rather than the particular needs of Aboriginal and Torres Strait Islander people. In addition to enhancing and expanding Aboriginal Community Controlled Health Services, it is important to get the mainstream health care system working in a way that delivers effective services for Aboriginal and Torres Strait Islander people. This includes improving linkages between Aboriginal Community Controlled Health Services and mainstream services.

Available data tells us that Aboriginal and Torres Strait Islander people don't systematically receive the levels of care, investigation and follow-up that clinical pathways recommend. For example:

- In 2005–06, Aboriginal people and Torres Strait Islanders were admitted to hospital for kidney dialysis at 14 times the rate of other Australians. They were also admitted to hospital at three times the rate for diabetes and diseases of the skin.[45]
- When admitted to hospital, Aboriginal and Torres Strait Islander patients are only two-thirds as likely to have a procedure recorded. For some categories it was as low as half.[46]
- Around three per cent of Aboriginal and Torres Strait Islander admissions result in the person leaving hospital against medical advice or being discharged at their own risk. Overall, Aboriginal and Torres Strait Islander patients are discharged from hospital against medical advice at 19 times the rate of other Australians.[47]

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

[46] Australian Institute of Health and Welfare (2005), The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2005 (Australian Institute of Health and Welfare: Canberra).

[47] Australian Health Ministers' Advisory Council (2006), Aboriginal and Torres Strait Islander Health Performance Framework 2006 report, AHMAC, Canberra.

Our submissions and national consultations suggested a number of strategies to improve clinical care (and competence), including accreditation for continuous quality improvement for Aboriginal and Torres Strait Islander health care. The Cooperative Research Centre for Aboriginal Health noted that:

> *Some hospitals have made efforts to provide culturally secure, quality services, including through the use of Aboriginal Hospital Liaison Officers, interpreters, engagement with the local Indigenous community, and development of written protocols on culturally secure practice*[48]

For example, the Mater Health Care Services Brisbane has developed specifically tailored services to meet the needs of Aboriginal and Torres Strait Islander people, including an Aboriginal and Torres Strait Islander Liaison service to provide increased access to services and to facilitate the admission, discharge planning and referral processes.[49] However, the problem is that these strategies have not been universally adopted.

A possible continuous quality improvement framework is described in Figure 8.9. Cultural competence, improving linkages across the health care system, encouraging more Aboriginal and Torres Strait Islander people to become health professionals, and the need to build a clinically and culturally competent workforce were also suggested.

Figure 8.9: A framework for Continuous Quality Improvement

The Cooperative Research Centre for Aboriginal Health proposes a continuous quality improvement framework against which hospital services can be audited in terms of their services to the Indigenous community, which could include:

- *promoting and requiring staff values, skills and knowledge related to cultural security;*
- *developing planning and evaluation relationships with the local indigenous community and its organisations and services;*
- *undertaking inter-agency and inter-disciplinary planning and evaluation focusing on the health needs of aboriginal people;*
- *developing systems and resources for internal referrals and discharge planning with the appropriate involvement of Aboriginal workers and agencies; and*
- *developing systems that support recording of Indigenous status and data collection, and that evaluates the effectiveness of that system.*

Source: Cooperative Research Centre for Aboriginal Health (adapted from the Australian Institute for Primary Care (2002), Aboriginal and Torres Strait Islander Accreditation: Final Report)

Participants at our national consultations reminded us of the importance of being culturally aware and sensitive to Aboriginal and Torres Strait Islander needs:

> *Greater attention needs to be given to patient communication in the cross-cultural context. Many Aboriginal patients arrive in hospital in Alice Springs with no family support, unable to speak the language and not familiar with how to use basic facilities such as taps, toilets etc. There are reports that patients consent to treatment without fully understanding the implications of procedures.*[50]

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[48] Cooperative Research Centre for Aboriginal Health (2008), Submission 527 to the National Health and Hospitals Reform Commission.

[49] Catholic Health Australia (2008), Submission 527 to the National Health and Hospitals Reform Commission.

[50] Health professional (12 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Alice Springs.

One way of ensuring services were more responsive to Aboriginal and Torres Strait Islander needs was to establish cultural brokerage services such as those provided by Karpa Ngarrattendi at the Flinders Medical Centre, Adelaide. As shown in Figure 8.10, the provision of culturally appropriate services does improve access for Aboriginal and Torres Strait Islander people.

Figure 8.10: Culturally appropriate health services improve access

A recent report into chronic care for Aboriginal and Torres Strait Islander people presented the following example of a culturally appropriate health service:

> *Inala is an urban area in Queensland, with an Aboriginal population of approximately eight per cent of the total population. A review conducted by the Inala Health Centre General Practice identified problems concerning poor access to health care services by Aboriginal people.*
>
> *In response, in July 1995 strategies aimed at increasing Aboriginal people's access to the Inala Health Centre General Practice were implemented. The strategies included employing an Aboriginal person in the centre, purchasing culturally appropriate health posters and artefacts for the centre to make Aboriginal people feel more at home, providing cultural awareness talks to all staff within the centre, disseminating information into the Aboriginal community about what services are available at the centre and promoting intersectoral collaboration.*
>
> *Before implementation the centre was not well used by local Aboriginal people, recording only 12 Aboriginal patient contacts in one year. In the program's first year of operation, there were 890 Aboriginal patient contacts, increasing to 3894 in 2000–01.*

Source: NSW Health (2008), The Walgan Tilly Project: Chronic Care for Aboriginal People, Final Report

Clinical excellence is as important as cultural safety, and a strong focus on both is needed to improve outcomes. Critical areas where there are proven strategies to achieve better health outcomes and improve life expectancy are maternal and child health (see Figure 8.4). As highlighted earlier, there is also significant potential to improve life expectancy by improving chronic disease care, and addressing those modifiable risk factors which contribute to chronic disease such as smoking, alcohol consumption and physical activity (see Figure 8.5). It may be appropriate that all services for Aboriginal and Torres Strait Islander people be required to demonstrate that they have evidence-based programs to address these as a key focus of their service delivery.

- Clinical excellence is as important as cultural safety, and a strong focus on both are needed to improve outcomes

There are critical shortages of all health professions across Australia, and Aboriginal and Torres Strait Islander people are under-represented in the health professions, with the exception of Aboriginal Health Workers. As outlined in Chapter 14, Aboriginal and Torres Strait Islander people make up only 1.6 per cent of the national health workforce.[51] While Aboriginal and Torres Strait Islander people account for 95.5 per cent of Aboriginal Health Workers, they only represent 0.2 per cent or less of all other health professions.[52]

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[51] A blueprint for action: pathways into the health workforce for Aboriginal and Torres Strait Islander people, Commonwealth of Australia 2008.

[52] A blueprint for action: pathways into the health workforce for Aboriginal and Torres Strait Islander people, Commonwealth of Australia 2008.

Maximising Aboriginal and Torres Strait Islander participation in the health workforce is a key strategy for improving access, health outcomes and life expectancy

The level of skilled professionals who are able to meet clinical and cultural needs is also an issue.[53] A focus on workforce development is an important element in delivering quality care. Maximising Aboriginal and Torres Strait Islander participation in the health workforce is a key strategy for improving access, health outcomes, and life expectancy.[54, 55] As emphasised in our national consultations:

> *Training of non-Indigenous professionals in cultural awareness and competence is crucial for those working in hospitals and other settings. The mainstream health environment needs to become 'safe' for Indigenous people and mechanisms need to be put in place to make hospitals 'comfortable' for Aboriginal staff and students.*[56]

The importance of removing financial barriers and creating linkages with other services is captured in the following comment made by a participant at the Alice Springs consultation:

> *Chronic disease is managed by so many different services that people can fall through the gaps. One major barrier is that no [private] GPs bulk bill. This makes it difficult for people who need regular services from a GP to access practitioners who could help them manage their condition.*[57]

8.3.4 Supporting community controlled health services

Community controlled health services play an important role in the delivery of comprehensive primary health care, maximising people's potential and removing illness as a barrier to Indigenous people's participation in family, community and workforce. Over 140 services are operating across Australia, ranging from large comprehensive primary health care services in urban areas to clinics in remote communities with only a few staff.

We heard through our consultations and submissions strong support for the enhancement of community controlled health services. This support is echoed in the statement:

> *Community controlled Aboriginal Health Services offer holistic primary health care and provide integrated primary health care models for indigenous people, including medical care, support for pregnancy and a good start to life, chronic and complex disease management and programs that address social and emotional health. However, there are gaps in investment and the workforce that need to be recognised and resourced. The sector needs to be supported to have the leadership role in the front line primary health care for Indigenous people.*[58]

As Figure 8.7 shows, Aboriginal and Torres Strait Islander people are relatively higher users of 'community health services' (the classification used for community controlled health organisations) and relatively lower users of general medical services. Community controlled health organisations are and will remain critical to the provision of good quality care to Aboriginal and Torres Strait Islander people. The Close the Gap Steering Committee for Indigenous Health Equality urged greater recognition of the vital role played by community controlled health services, including closer engagement by the Commonwealth Government with this sector.[59]

There is considerable diversity within the community controlled health sector with significant differences in the levels of infrastructure and staffing, and consequently the range of services offered

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[53] The National Evaluation of the Second Round of Coordinated Care Trials, Final Report.

[54] A blueprint for action: pathways into the health workforce for Aboriginal and Torres Strait Islander people, Commonwealth of Australia 2008.

[55] Australian Indigenous Doctors' Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

[56] Participant (26 June 2008), National Health and Hospitals Reform Commission special interest forum on Indigenous health in Melbourne.

[57] Health professional (12 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Alice Springs.

[58] Participant (26 June 2008), National Health and Hospitals Reform Commission special interest forum on Indigenous health in Melbourne.

[59] Close the Gap Steering Committee for Indigenous Health Equality (2008), Submission 510 to the National Health and Hospitals Reform Commission.

and their effectiveness. A critical mass is needed to ensure sustainability of these organisations. The Queensland Aboriginal and Islander Health Council summarised the issues facing community controlled health services, and the need for support:

> *There is a minimum size below which health care organisations cannot be effective. Achieving critical mass and addressing capacity issues is important to ensure sustainability of programs … funding increases will not lead to improved outcomes unless organisations are supported to improve capacity in terms of financial planning and management, recruiting and retaining a mix of staff, implementing health information systems and leadership.*
>
> *Governments urgently need to provide more enabling policy frameworks and program guidelines that actively promote Indigenous capacity and authority. At a minimum, governance needs to meet broader standards of corporate governance as well as ensuring cultural legitimacy and that organisations are run productively and in a way that reflects local priorities. People involved in the organisation (the board, the chief executive officer, administrators, and clinical staff) all need to understand their roles and responsibilities, and be supported to work within these boundaries.*[60]

8.4 Creating a better future

Our reform directions focus on what we believe needs to happen to close the health gap and to build a health system that is responsive to the needs of Aboriginal and Torres Strait Islander people regardless of where people live. There are several inter-related dimensions to doing this.

First, we believe that there is significant potential to close the life expectancy gap within the health sector alone, but that there will be a positive compounding effect if all social determinants of health were tackled in a whole of government and whole of community approach.

Reform direction 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.

Second, we are strongly of the view that additional investment is needed if the goal of closing the gap by 2030 is to be achieved. We believe that funding should be determined on the basis of health need but also take account of the additional costs associated with delivering services outside metropolitan areas. We also believe that increased ongoing investment should be staged over five years to build primary health care capacity across the continuum of health promotion, prevention and clinical care. We note that the Close the Gap National Indigenous Health Equity Targets suggest that additional funding is needed of $150m, $250m, $350m, $400m, and $500m per annum over 5 years with the $500m sustained in real terms until the health gap is closed.[61] We also note the additional investment announced by COAG on 30 November 2008.

■ We are strongly of the view that additional investment is needed if the goal of closing the gap by 2030 is to be achieved

Reform direction 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.

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[60] Queensland Aboriginal and Islander Health Council (2008), Submission 483 to the National Health and Hospitals Reform Commission.

[61] Close the Gap Steering Committee for Indigenous Health Equality (2008), National Indigenous Health Equality Targets.

Our third reform direction concerns Aboriginal Community Controlled Health Services. We believe that increased investment is required to ensure equitable access to effective primary health care. This means additional coverage of some areas, and increased capacity in others.

We also believe additional support is required to assist Aboriginal Community Controlled Health Services build organisational capacity. We expect that this would include governance and leadership, financial planning and management, and recruitment. Existing partnership and planning arrangements have a role to play, but the critical need is implementation.

Some Aboriginal Community Controlled Health Services are small and the regulatory burden on them is sometimes out of proportion to the funds they manage. Establishing new fragile organisations to help address the health gap is not the way to go. Strategies to strengthen Aboriginal Community Controlled Health Services could include greater sharing of administrative resources, skills development of staff and boards, establishing central or regional support services, and tighter grouping of some organisations. These support functions are important and are critical to building a strong network of Aboriginal Community Controlled Health Services.

The 'support' function should possibly be separate from the 'purchasing' function or there may be a potential conflict of interest in promoting the rigorous accountability for care quality that we envisage will be part of the role of the National Aboriginal and Torres Strait Islander Health Authority (see reform direction 8.4).

Reform direction 8.3

We propose establishing a function to build and expand organisational capacity of Aboriginal 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.

Our fourth reform direction concerns funding flows. We believe that a new approach to purchasing health services for Aboriginal and Torres Strait Islander people is needed if Australia is going to address the 17-year life expectancy gap for this 'discrete, disadvantaged' group of Australians.

We have argued the critical need to improve access to primary health care through both Aboriginal and Torres Strait Islander-specific and mainstream services. The community controlled sector needs to be expanded to achieve access to primary health care, particularly in rural and remote areas. The mainstream health sector needs to become more culturally appropriate to root out residual racism and to pay more attention to the particular needs of Aboriginal and Torres Strait Islander people. We believe that this can be done by changing the way funds flow to all services, and by strengthening the accountability of mainstream services (including hospitals and general practices).

We have argued in Chapters 2 and 3 that we can improve care of people with chronic disease and care of people in their early years if we work with a defined population, identified through voluntary enrolment. Aboriginal and Torres Strait Islander people should also be able to enrol with a primary health care service, including Aboriginal Community Controlled Health Services. In addition, we suggest that this concept could be further extended so that Aboriginal and Torres Strait Islander people have an entitlement to services that are purchased through a new 'purchasing' organisation.

Reform direction 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.

Underpinning the establishment of an Aboriginal and Torres Strait Islander Health Authority (Authority) would be acknowledgement that improvement in Aboriginal and Torres Strait Islander health is important to Australia and that there is a need for consolidated, affirmative action to build a system that will meet the needs of Aboriginal and Torres Strait Islander people, similar to that afforded to the veteran community.

We envisage the Authority would function for the Aboriginal and Torres Strait Islander people in much the same way as the Repatriation Commission/Department of Veterans' Affairs does for the veteran community. Initially, the Authority could potentially use the same contractual arrangements and the same quality assurance mechanisms as does the Department of Veterans' Affairs.

The Authority would have a 20-year life cycle linked to the timing of the Prime Minister's commitment to close the life expectancy gap by 2030, but subject to evaluation on a regular basis to ensure that the Authority is driving the improvements that it has been set up to achieve. The first evaluation, after, say, two years of existence, would evaluate whether it has established robust systems of contracting with appropriate internal evaluation mechanisms.

The Authority would be funded to broker/purchase health services for Aboriginal and Torres Strait Islander people and to ensure appropriate advocacy services. Purchasing may seem bureaucratic, but purchasing determines the way funding flows to health services in ways that can deliver improved outcomes. The Authority would have two sources of funding:

- funding currently directly allocated for mainstream services – for example, under the Australian Health Care Agreements and Medicare, Closing the Gap additional investment, and through the Office of Aboriginal and Torres Strait Islander Health; and
- additional funding to meet need, for advertising campaigns, and supplementary services.

The Commonwealth Government's Department of Health and Ageing would still have overall responsibility for Aboriginal and Torres Strait Islander health, and should continue to ensure that Aboriginal and Torres Strait Islander health is 'everybody's business'.

Services would be purchased from Aboriginal Community Controlled Health Services, mainstream primary health care services and hospitals, and other services. The Authority would ensure that all purchased services meet set criteria including clinical standards, cultural appropriateness, appropriately trained workforce, data collection and performance reporting against identified targets such as the national Indigenous Health Equality Targets.

Aboriginal and Torres Strait Islander people would need to register to receive services funded through the Authority. Registration would be voluntary, and those not registered would still be covered by existing Medicare arrangements.

This approach would support access to health services for Aboriginal and Torres Strait Islander people through direct billing, the provision of clinically sound and culturally appropriate services within mainstream primary health care, and improved linkages between all health services. The Authority should also be able to simplify contractual and accountability arrangements for Aboriginal Community Controlled Health Services.

We expect that the Authority would publish a three year plan and report each year on how its activities are contributing to closing the health gap.

The Authority could be established separately or within the Office for Aboriginal and Torres Strait Islander Health (OATSIH) – either way, it will represent a significant change for OATSIH. But, we consider that the policy and purchasing functions for Aboriginal and Torres Strait Islander health should remain separate.

The Authority would also have some capacity to address socio-economic determinants of health. Similar to the Victorian Transport Accident Commission, which funds advertisements and other interventions to encourage people to drive safely, the Authority could also have a capacity to run targeted campaigns to address risk factors – for example, an anti smoking campaign aimed at primary school children.

Governments have recognised that 'more of the same' is not an adequate response and will not close the health gap

Governments have recognised that 'more of the same' is not an adequate response and will not close the health gap. A new approach is required to drive improvement in the quality and responsiveness of the whole health system for Aboriginal and Torres Strait Islander people.

Interestingly, there is at least one small scale 'purchasing' or brokerage of services already operating. The North Coast Aboriginal Corporation for Community Health operates on a brokerage model, with 22 voluntary referral officers, and approximately 150 service providers registered for referral.[62] Eligible clients are issued with a health access card.

Our fifth reform direction relates to the accreditation of health services. We believe that accreditation linked to high quality clinical and culturally secure services will improve access and treatment for Aboriginal and Torres Strait Islander people. As described earlier, evidence suggests that Aboriginal and Torres Strait Islander people do not routinely receive the same level of care afforded to other Australians.

Reform direction 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.

Our sixth reform direction relates to workforce, but has two dimensions.

The first dimension is the need to encourage more Aboriginal and Torres Strait Islander people into the health professions as a strategy for improving access for other Aboriginal and Torres Strait Islander people to health services; to provide professional opportunities for Aboriginal and Torres Strait Islander people; for providing role models within the community; and for increasing productivity.

The second dimension is about building a workforce for Aboriginal and Torres Strait Islander health. This would ensure that all health professionals are clinically and culturally competent and understand the public health issues specific to Aboriginal and Torres Strait Islander health, and would be able to respond in a way that is effective and meets their health needs. This is explained in more detail in Chapter 14 on workforce.

Reform direction 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.

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[62] C Shannon and K Panaretto, Analysis of Maternal and Child Health Services in Selected Aboriginal Community Controlled Health Services in Queensland, Queensland Aboriginal and Islander Health Council.

9. Delivering better health outcomes for remote and rural communities

Key messages

- Australia is a vast continent with the majority of the population living in regional or urban areas. Remote and rural areas and the people who live in them are important to Australia's economic base, food security and our national identity. Our natural assets of wide open spaces, cultural diversity and distance are also our greatest challenges in health services provision.
- People's health outcomes worsen with remoteness.
- While the health outcomes of Aboriginal and Torres Strait Islander people across Australia are universally worse, remoteness poses additional health service challenges in closing the gap.
- Health challenges have seen the remote and rural health sectors become a source of significant innovation in health service delivery, systems of care, quality improvement, and education. Their experience related to the significant burden and early onset of chronic disease will enable remote and rural health to provide leadership and testing of future health service development and innovation.
- Locally designed and responsive primary health care services are the foundation of accessible quality health care for people in remote and rural areas. They require flexible funding arrangements to reconfigure their services to best meet their distinct local needs.
- Access to quality health care requires the care to be brought to the people or the people to be transported to the care. Hence, primary health care services in a remote or rural context need to include the provision of emergency care, retrieval services and repatriation.
- Continuity of care in remote and rural contexts requires all health care practitioners or professionals to be formally linked. Physicians, midwives, allied health, pharmacists, paediatricians, obstetricians and gynaecologists and psychiatrists need to be community based or have a formal outreach role in supporting primary health care services.
- Health professionals who are from remote or rural areas or who undertake their education and training in remote or rural areas are more likely to work in those areas.
- Building a quality workforce in remote and rural areas is a complex challenge and requires sophisticated strategies of recruitment and support from undergraduate through to specialist training and continuing professional development across the disciplines.
- The multiplicity, complexity, rigidity and administrative requirements of current funding silos result in service gaps, inefficiency and poorer health outcomes.

Our reform directions

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 populations; 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.

9.1 Defining and scoping remote and rural health

Nearly one-third of Australians live in remote and rural areas, with three per cent in remote areas

Nearly one-third of Australians live in remote and rural areas, with three per cent in remote areas.[1] Of the seven million Australians who live outside major cities, two million live across Australia in communities and settlements of less than 200 people. Rural towns and communities come in different sizes:

- There are 1459 towns with a population between 200 and 5000.
- There are 139 bigger towns with a population between 5000 and 18,000.
- There are a further 39 towns with a population between 18,000 and 48,000.[2]

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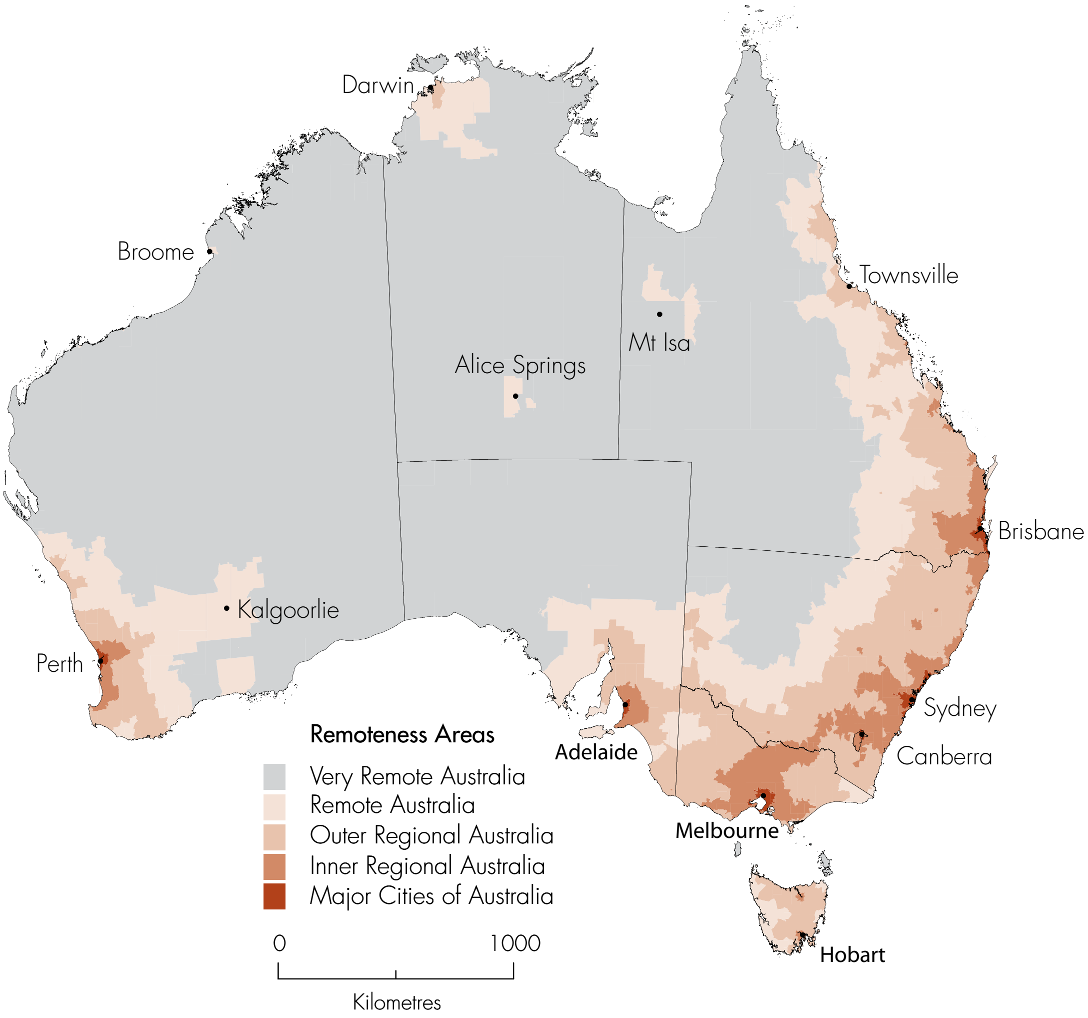
[1] Australian Institute Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

[2] J Best (2000), Rural Health Stocktake Advisory Paper (Department of Health and Aged Care: Canberra).

Figure 9.1: One-third of Australians live in remote and outer regional areas



Source: Australian Bureau of Statistics (2008), Australian Social Trends, 2008, at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter3002008

Although Australia's population continues to grow, remote and rural areas are growing at a slower rate than the national average of 1.6 per cent. There continues to be a shift of people from the bush to the cities seeking work because of changes in farming and the impact of long periods of drought.

Aboriginal and Torres Strait Islander people comprise 24 per cent of the population in remote areas.[3] Australians in the bush generally have poorer health than people in the city, particularly influenced by the higher share of Aboriginal and Torres Strait Islander people living in these areas.

People in remote and rural areas[4]:

- tend to have shorter lives, higher levels of illness and more disease risk factors;
- have a poorer health status that increases with remoteness, and is worse for Aboriginal and Torres Strait Islander people;
- have higher rates of accident and injury;

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[3] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

[4] Australian Institute of Health and Welfare (2008), Rural, regional and remote health: Indicators of health system performance (Australian Institute of Health and Welfare: Canberra).

- are more likely to have earlier onset and higher rates of certain chronic diseases and preventable cancers such as those associated with sun exposure or smoking; and
- have lower rates of certain medical treatments – for example, death rates from heart disease are 40 per cent higher than in cities but coronary artery bypass grafts are 30 per cent lower in rural and regional areas.

Indicators such as smoking and alcohol consumption suggest that public health strategies have not yet reached the young population of remote and rural areas. A higher proportion of people living in remote areas reported daily or current smoking (28 per cent) compared with those living in major cities (20 per cent). This difference was particularly marked among men and women aged 25 to 44 years.[5]

The costs of delivering services are much higher in remote and rural settings than in metropolitan settings ■

In remote and rural Australia, there are fewer services than in the cities. Country people are often disadvantaged in the areas of education and employment, and also in access to goods and services. They have fewer choices when it comes to schools, jobs, shopping centres, clubs, community groups, open spaces, and sports and leisure activities. In remote Australia these differences are stark. In some areas, there is no, or limited, access to basic necessities such as clean water and a reliable affordable supply of fresh food. Significantly, the costs of delivering services are much higher in remote and rural settings than in metropolitan settings. Conversely, some areas of remote Australia contribute a significant proportion of the nation's wealth and even these areas struggle to have reliable health services provided.

Generally, there are fewer health services. At the same time, the data paints a very limited picture of what services are provided by what types of health professionals[6]:

> *Currently remote practice is invisible in the national data set – the data is not collected, so tracking of progress or analysis of trends in primary care is not at all possible.*

People who live in remote and rural areas acknowledge that, given budgetary constraints, it is not possible for government to provide the same level of health services to all.[7] However, they have the right to expect reasonable access to health services, including primary health care, prevention and health promotion, with health outcomes equivalent to people living in larger regional and metropolitan areas. In the words of the Health Consumers of Rural and Remote Australia[8]:

> *… health services in rural and remote areas would be improved significantly if the 30% of the population living in these areas received a similar percentage of health funding.*

9.2 Building on our strengths

Historically, the support and connection between remote and rural people and their services has been creative. Many small country hospitals were built or equipped by remote and rural people and their organisations. Examples include:

- The Country Women's Association built maternal and child health facilities in many of their halls across Australia.
- In more recent times, the Western Desert Dialysis program was funded by the Pintubie artists of Kintore.

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[5] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

[6] CRANA (2008), Submission 73 to National Health and Hospitals Reform Commission.

[7] Health Consumers of Rural and Remote Australia (2008), Submission 393 to National Health and Hospitals Reform Commission.

[8] Health Consumers of Rural and Remote Australia (2008), Submission 393 to National Health and Hospitals Reform Commission.

There have been many achievements in remote and rural health in recent years: most importantly, health improvement. A range of innovative health service and support initiatives has been implemented across Australia, noting that an integral component to their success has been flexibility:

> *Service models must vary in order to take account of the specific geographical, social, economic and cultural contexts that differentiate the many remote and rural communities …*[9]

Remote and rural health has been regarded as a responsibility of both state/territory and Commonwealth governments. To date, this has been acknowledged by the Australian health ministers' endorsement of two national frameworks for joint government action.

The first National Rural Health Strategy in 1994 was a Commonwealth and state/territory initiative that recognised the importance of flexibility in meeting the diversity of local need and circumstances.[10] It was replaced by the Healthy Horizons Framework in 1999.[11] The second version of Healthy Horizons in 2003 acknowledged the changing environment for health. That is, while access to hospital care was fundamental to health needs, there was an increased focus on illness prevention, long-term care and step up and step down services.[12] However, there is still scope for much improvement in support for primary health care in remote and rural communities.

We should also build on current strengths, while learning from the complexities and outcomes at the program level. There are a range of rural health strategies and activities covering some elements of workforce, primary health care, mental health and aged care. An example is the Medical Specialist Outreach Assistance Program which improves access to specialist medical services for some remote and rural communities. This program provides funding to specialists to cover some costs in delivering outreach services including travel and accommodation, and delivery of training and up-skilling to local practitioners. During 2001–02, there were 150 services operational under the program, compared to more than 1400 services being provided in 2007–08.[13] As part of the May 2008 Federal Budget, the Commonwealth committed an additional $12 million over four years to support the expansion of the program. Longer-term strategic planning is, however, still needed for medical specialist services.

There have also been initiatives which have trialled alternative funding arrangements such as the Coordinated Care Trials. The trials were an initiative of the Commonwealth, state and territory governments aimed at strengthening primary health care to better meet the challenges associated with chronic disease management. The intention was to explore and test innovative approaches to the funding and delivery of health services more in line with and responsive to the needs of people with chronic and long-term health conditions.[14]

Benefits of the Aboriginal and Torres Strait Islander coordinated care trials were achieved at a population health level and at funding levels still below mainstream norms. They found, importantly, that there was an increased access by people of services, including due to the provision of more culturally appropriate services. Underpinning these services was access to primary health care, best practice clinical guidelines and a developing system of care. Despite the success of these trials, application of the model has been limited. The Primary Health Care Access Program, which provided funding for the expansion of comprehensive primary health care services in Aboriginal and Torres Strait Islander communities, was hailed to be the next generation, yet has been limited in its implementation.

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[9] J Humphreys and J Wakerman (2008), Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform, Discussion paper commissioned by National Health and Hospitals Reform Commission.

[10] Commonwealth of Australia (1994), Australian Health Ministers' Conference, National Rural Health Strategy 1994, at: http://nrha.ruralhealth.org.au/cms/uploads/publications/strat94.pdf

[11] National Rural Health Policy Forum and National Rural Health Alliance, Healthy Horizons 1999–2003, A framework for improving the health of rural, regional and remote Australians, at: http://www.health.nsw.gov.au/policy/hsp/hhoriz/1front.pdf and Australian Health Ministers Advisory Council, Healthy Horizons Outlook 2003–2007, A framework for improving the health of rural, regional and remote Australians, at: http://nrha.ruralhealth.org.au/cms/uploads/publications/hh_2003_03.pdf

[12] Australian Health Ministers Advisory Council, Healthy Horizons Outlook 2003–2007, A framework for improving the health of rural, regional and remote Australians, at: http://nrha.ruralhealth.org.au/cms/uploads/publications/hh_2003_03.pdf

[13] Department of Health and Ageing (2008), Information for National Health and Hospitals Reform Commission.

[14] Department of Health and Ageing (2007), The National Evaluation of the Second Round of Coordinated Care Trials: Final report (Commonwealth of Australia).

Other strengths of remote and rural health services include:

- the development and successful implementation of clinical guidelines in remote primary health care such as the Central Australian Rural Practitioners' Association (CARPA) Standard Treatment Manual;
- systems of care including quality improvement programs such as the Audit and Best Practice for Chronic Disease project[15]; and
- clinical education with the pioneering of the parallel rural community medical curriculum in a rural setting[16] and rural clinical schools.

Rural general practitioners and general practitioner proceduralists, nurses, midwives and community health continue to provide comprehensive care in many regions, many with formal teaching as a routine part of their activities, and often because of personal relationships and longevity in the town rather than service structure. Submissions and forums identified more flexible funding arrangements as a means to build on this. The Far North West Queensland Allied Health Outreach Service is an example of where flexibility of funding and a critical mass of professionals with good support have facilitated unprecedented reach of their services.[17]

A major strength of health service delivery in remote and rural areas is the multidisciplinary team approach to care and a focus on generalists ■

A major strength of health service delivery in remote and rural areas is the multidisciplinary team approach to care and a focus on generalists – a model frequently recommended in our frontline consultation forums around Australia[18] and in several submissions. In the words of one submission[19]:

> *Collaborative practice and teamwork is a strong feature of remote practice. All professionals are required to work beyond traditional boundaries; there is much less patch protection and more genuine professional respect and support that have resulted in a strong collegiality.*

It is therefore important to build on initiatives, past and present, noting the lessons learnt. There is still much to be achieved in order to improve the health of people in remote and rural Australia, to overcome disadvantage and to meet future challenges.

9.3 Identifying the case for change

The health needs of Australian communities in remote and rural areas are still not being adequately met.

Specific health status measures illustrate the generally poorer health of people living in remote and rural areas. For example, compared with people who live in cities, the life expectancy of people in regional areas is one to two years lower and for people in remote areas it is up to seven years lower due to higher coronary heart disease, other circulatory disease, and accidents.[20] The lower life expectancy in remote areas is largely due to the reduced life expectancy of Aboriginal and Torres Strait Islander Australians, which is about 17 years lower than that of Australians overall.[21]

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[15] RS Bailie and colleagues (2007), 'Indigenous health: effective and sustainable health services through continuous quality improvement', Medical Journal of Australia 186(10): 525–527.

[16] LK Walters and colleagues (2003), 'The parallel rural community curriculum: is it a transferable model?', Rural and Remote Health, The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, 1–9.

[17] J Symons (2006), 'Is it a bird? Is it a plane? No, it's an allied health professional', paper presented to National Services for Australian Rural and Remote Allied Health (SARRAH) Conference.

[18] Consolidated frontline health worker report, National Health and Hospitals Reform Commission, at: http://www.nhhrc.org.au

[19] CRANA (2008), Submission 73 to National Health and Hospitals Reform Commission.

[20] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

[21] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

Figure 9.2: People living in rural and remote areas have worse health outcomes than people living in urban areas

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
	Years				
Life expectancy at birth (males) (2002–04)	*79*	*78*	*77*	*77*	*72*
Life expectancy at birth (females) (2002–04)	*84*	*83*	*83*	*82*	*78*
	Standardised ratio				
Deaths (all ages, 2002–04)	*1.00*	**1.07*	**1.12*	**1.18*	**1.69*
Deaths, non-Indigenous (all ages, 2002–04)	*1.00*	**1.07*	**1.11*	**1.05*	*1.00*
Deaths < 65 years (2002–04)	*1.00*	**1.15*	**1.29*	**1.50*	**2.74*
Deaths < 65 years, non-Indigenous (2002–04)	*1.00*	**1.14*	**1.23*	**1.10*	**1.13*

* Statistically significant difference from Major Cities.

Source: Australian Institute of Health and Welfare (2008), Australia's Health 2008

We heard through our national forums[22] a number of common themes in relation to health care in remote and rural areas. Key concerns included the importance of community engagement; workforce shortage/mal-distribution; accessing specialist services; interdisciplinary training; support and access to professional development for health professionals; and the issue of funded patient travel to access health services not available locally. Better use of technology to deliver health services, including an electronic health record, unique health identifier and full broadband service, were also recurring hemes.

These issues all impact on the case for change, with workforce being an area where particular consideration needs to be given to innovative models:

> *Particularly in rural and remote areas, a new health system must be less dependent on health professionals. This will mean keeping people healthy through early intervention, health promotion and promoting healthy environments, enabling people to engage more fully in disease self-management, redesigning professional roles and partnerships, and finding appropriate funding methods for a range of diverse circumstances.*[23]
>
> *In remote and very remote areas, there are around 248 clinics staffed by 623 remote area nurses and 34 very remote hospitals with 1491 nurses and a further 54 remote hospitals. The strength of this is that they are located where people live. The number of RANs who are largely isolated, in the overall scheme of things, is small; however, the impact of their role is critical – they largely provide the service. While the remote area nursing workforce is very dispersed, supporting its deliberate development together with the similar small number of managers, Aboriginal health workers, doctors and allied health professionals to provide high quality health care is achievable.*[24]

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[22] For example, National Health and Hospitals Reform Commission consultation meetings (2008) with communities in Darwin and Cairns and frontline health workers in Dubbo.

[23] National Rural Health Alliance (2008), Submission 333 to National Health and Hospitals Reform Commission.

[24] CRANA (2008), Submission 73 to National Health and Hospitals Reform Commission.

Primary health care funding provided on a fee-for-service basis through Medicare is not accessed by many small remote and rural communities

- Health care delivery design needs to be different in small communities, with the response more integrated than in larger communities. For example, service delivery in remote and small rural areas is not supported by the current funding model. In remote areas, primary health care is largely provided by remote area nurses and Aboriginal health workers with the majority of remote medical practitioners providing remote outreach and remote telephone support. The number of resident general practitioners is very small and they too identify the need for additional support. Primary health care funding provided on a fee-for-service basis through Medicare is not accessed by many small remote and rural communities because most are not sufficiently serviced by resident general practitioners. Most day-to-day remote primary health care services are provided by other professionals such as Aboriginal health workers and nurses who are not able to access most Medicare refundable items. Allied health services are varied and more invisible in national datasets.

Many doctors work in remote areas on a visiting basis, with associated travel time; few are resident, and many of those who are resident work under a fly-in fly-out rotation model. This reduces traditional patient throughput and Medicare income. Many comprehensive primary health care services, particularly population health and health promotion services locally delivered, are not refundable under Medicare; and even where Medicare services are claimable, the actual costs of delivering this service in a remote area are much higher than in urban or rural settings. Larger rural towns that support a combination of general practice (many who are general practitioner proceduralists), community health, and a hospital also require similar regional planning, governance and flexible funding to best meet local need – shared care between general practitioner obstetrician and midwife, for example.

There is a need for flexible funding arrangements that focus on both multidisciplinary practice and prevention targets. The multidisciplinary health teams, including nurse practitioners, are fundamental to provision of adequate health service delivery in remote and rural communities. Strengthened primary health care is central to the coordination and continuity of care and includes outreach specialists, mental health, pharmacy, dental and allied health services. Primary health care is responsible for referring out, receiving back and follow-up of care in the context of the person’s family and community. It needs to be supported by access to expert telephone advice, specialist consultation, regionally-organised public health and prevention, retrieval services and improved access to telehealth and patient care technologies.

In many remote areas, high birth rates present the system with an immediate challenge as to how best to support children to be productive and healthy adults, and to give the children soon to be born the best start in life. Current and projected rates of chronic disease also present a convincing case for change. Risk factors such as smoking and alcohol intake pose significant public health challenges. If the health service is not robust and comprehensive, remoteness and rurality, in itself, is a significant risk factor for many who live there.

Remote and rural health services, small and large, identified multiple short-term rigid funding silos, with complex and duplicated reporting requirements, as major barriers to the provision of quality care and services.[25]

In identifying the case for change, it is vital that we look to the future. In remote and rural Australia, the big issues that influence and impact on the towns and communities and their economy include the weather and international commodity markets as well as transport, such as airlines and tourism. Hence, remote and rural communities are vulnerable to external shocks as well as local events. The frequency and severity of drought are likely to increase, and in between many periods are likely to be hotter, impacting on crop survival and dryness with both a physical and a social component leading to major upheaval and stress in rural communities which unfolds over years. Changes in vector-borne disease will need to be monitored. This will affect communities’ ability to attract and retain their residents. Based on such challenges, various experts have indicated the need to be planning for health needs of the future – that is:

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[25] Health professionals (3 June 2008 and 2 July 2008), National Health and Hospitals Reform Commission consultation meetings with frontline health workers in Dubbo and Darwin.

> *… greater investment in the capacity of existing primary and allied health care services in rural communities to enable them to be responsive to the physical and mental health impacts of future dryness. Governments must be more effective in encouraging people in rural communities to self-identify their health needs and to be able to seek appropriate support at an early stage.*[26]
>
> *Forecasts also include more frequent or severe wild weather events in Australia and the region. This has significant implications to remote and rural health services, particularly across northern Australia in responding to such events in the emergency and recovery periods.* [27]

9.4 Creating a better future

A critical reciprocal relationship exists between services, especially health services, and sustainable communities. Access to appropriate health care is therefore of prime importance to residents in remote and rural areas. 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.*[28]

A critical reciprocal relationship exists between services, especially health services, and sustainable communities

A more localised or 'natural regional' approach to the delivery of primary health care services in order to meet communities' diverse needs was recommended in both submissions and the national consultations. Characteristics of such an approach could include:

- population size small enough to enable a responsiveness to local issues and yet sufficient to support an essential range of services;
- service area boundaries to reflect natural catchments/communities of interest and transcend state borders;
- cashing out and/or pooling of funds from multiple Commonwealth and state programs with streamlined reporting arrangements. This would enable flexibility in how funding is used and services delivered to the communities.
- delivery of services funded though payments, i.e. a mix of core funding, fee for service, salary and targeted incentives;[29] and
- capital and infrastructure support may be necessary to facilitate co-location of services such as community health, general practice, ambulance, hospital and aged care.

As we have noted, many Australians in remote and rural areas do not have equitable access to quality health care. They do not have '… equal access to equal care for equal need'[30] due to a combination of factors including geographical isolation and lack of or underpowered health services and a higher burden of disease. We believe there is a need to build on existing financing arrangements to recognise contemporary needs better, noting that people in remote and very small rural areas are often unable to access traditional general practitioner or community health services because there are few or none. Submissions have suggested that it would be worth looking at the development of appropriate Medicare models for services provided by remote area nurse practitioners and midwives[31], remote medical telehealth support, while the option of differential rebates for medical practitioners has also been proposed.[32]

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[26] Drought Policy Review Expert Social Panel (2008), Report to the Minister for Agriculture, Fisheries and Forestry, Canberra, It's about People: Changing Perspectives, A Report to Government by an Expert Social Panel on Dryness (Commonwealth of Australia).

[27] Bureau of Meteorology and Australian Commonwealth Scientific and Research Organisation (2008), Drought exceptional circumstances: An assessment of the impact of climate change on the nature and frequency of exceptional climatic events (Commonwealth of Australia).

[28] Rural Doctors Association of Queensland (2008), Submission 499 to National Health and Hospitals Reform Commission.

[29] National Rural Health Alliance, NRHA seeks an overhaul of rural health, at: http://www.achse.org.au/ebulletin/Networker/nrha_overhaul.pdf

[30] SR Leeder (2003), 'Achieving equity in the Australian healthcare system', Medical Journal of Australia, 179 (9):475–478.

[31] CRANA (2008), Submission 73 to National Health and Hospitals Reform Commission.

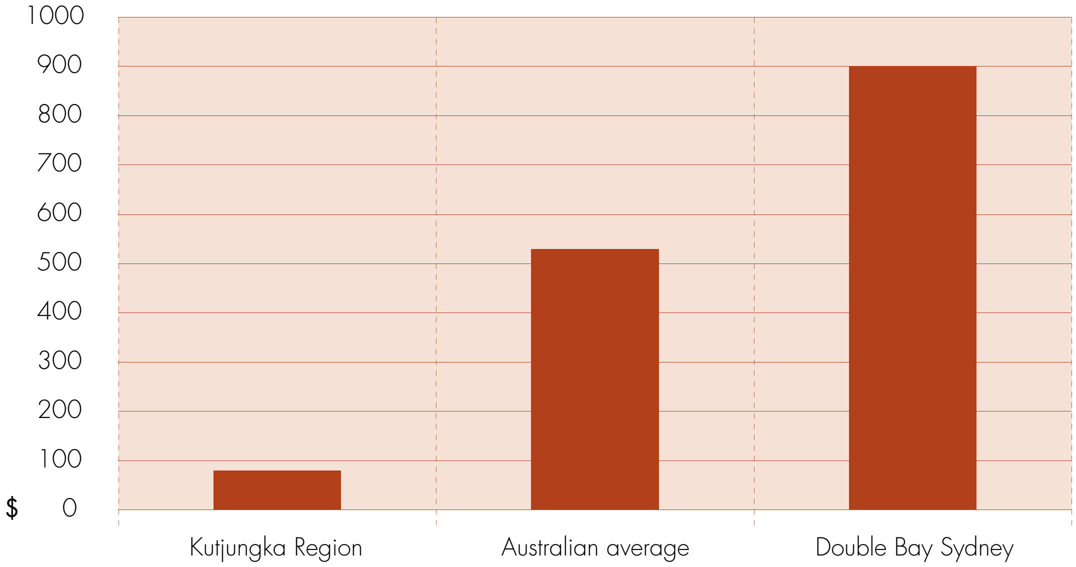
[32] Rural Doctors Association of Australia (2008), Submission 154 to National Health and Hospitals Reform Commission.

9.4.1 Applying equity across primary health care funding

We believe the principle of equity for Medicare and primary health care funding should be applied across the board. It is well documented and understood that Medicare, as a universal demand-driven system and as rebate-funded health care, cannot be accessed by a number of people, including Aboriginal and Torres Strait Islander people, in most remote and rural communities. For example, there are very different levels of access to MBS and PBS funding for some communities (see Figure 9.3), an issue which was raised in several submissions:

> *The most fundamental of these barriers is the system of Medicare rebates and the Pharmaceutical Benefits Scheme (PBS) which constitute 34 per cent of total federal and state government health expenditure. Of this spending $432 per person is spent in capital cites, $417 in outer metro areas, $350 in rural and remote areas, and a paltry $240 on Aborigines and Torres Strait Islanders. This is the inequity flaw built into the structure of the Medicare system. If there is no doctor in an area then there is no funding through Medicare rebates and the PBS. If there are plenty of doctors, the area gets huge funding.*[33]

Figure 9.3: In 2003, Australians used Medicare-funded primary health care from less than $80 per person in remote WA to more than $900 per person in metropolitan Sydney



Source: G Mooney (2003), 'Inequity in Australian health care: how do we progress from here?', Australian and New Zealand Journal of Public Health, 27 (3):267–270.

Data is not available on the level of community health and non general practitioner primary health care services provided across Australia, so this represents only some of the picture. It is recognised, however, that all are underfunded. At the same time, what has been learnt is that governments have trouble delivering services across the board in remote and rural communities.[34]

In order to deal with disadvantage, disadvantage needs to be factored into the funding formula across primary health care for remote and rural areas. For example, the funding model for the Aboriginal and Torres Strait Islander coordinated care trials utilised funds pooling and cashing out of MBS and PBS funds, based on per-capita utilisation and loaded for remoteness and morbidity. These strategies were effective because they created additional funds and gave flexibility in

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[33] Doctors' Reform Society (2008), Submission 78 to National Health and Hospitals Reform Commission.

[34] Desert Knowledge Australia (2008), Prospectus, remoteFOCUS: Revitalising Remote Australia (remoteFOCUS).

use of funds which resulted in a greater focus on local needs.[35] It is interesting to note that these services were quickly encouraged to utilise Medicare funding in recognition of the need for additional investment.

More equitable health care requires more equitable distribution of funding resources. This means that funding based on the average per-capita utilisation figure for Medicare should be appropriately adjusted for remoteness and morbidity and then applied to under-served populations in remote and rural areas. This concept also needs to be applied across the whole suite of primary health care funding.

9.4.2 Meeting the needs of diverse remote and rural communities

There is no 'one size fits all' model which can service the health needs of diverse remote and rural communities. Service models should, therefore, focus on ensuring that key service requirements and community needs are met. This requires systemic changes relating to[36]:

- regional models designed to maximise access to appropriate comprehensive primary health care;
- financing arrangements that resource communities independently of workforce availability;
- a service focus on health promotion and early intervention;
- multidisciplinary teams that maintain a strong medical input;
- adequate infrastructure to support an appropriate medical and health workforce;
- a mechanism for monitoring progress against agreed indicators and targets, ensuring quality and accountability for all players; and
- community engagement.

■ There is no 'one size fits all' model which can service the health needs of diverse remote and rural communities

Evidence on how remote and rural areas shape the nature of practice and service delivery shows there is a need to tailor service delivery to the populations. It is also important to have a critical population mass for an effective health service model and frame it within a primary health care framework.[37] Under the current financing arrangements, there is a critical level of population below which sustaining a business model of a locally available, safe and affordable range of primary health care services may not be considered viable.

Some remote and small rural communities currently have neither the critical mass nor the infrastructure to enable the residents to receive the range of clinical and health services characteristic of large urban centres. These require alternative service models with different funding arrangements, supported by a regional organisation which will have the critical mass for the provision of core and outreach services to effectively meet local need.

9.4.3 Expanding the multi-purpose service concept

There has been a history of alternative models in health service delivery in remote and rural areas, particularly in small towns. In 1992–93 the Commonwealth and state/territory governments established the Multipurpose Services (multi-purpose service) program as a model of service delivery to address the difficulties of providing health, aged and community services in remote and rural communities.[38] The program responds to a range of issues which may be evident in particular rural communities including isolation from mainstream services, difficulties in attracting and retaining

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[35] J Wakerman and colleagues (2006), A systematic review of primary health care delivery models in rural and remote Australia 1993–2006 (Australian Primary Health Care Research Institute).

[36] J Humphreys and J Wakerman (2008), Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform, Discussion paper commissioned by National Health and Hospitals Reform Commission.

[37] J Humphreys and J Wakerman (2008), Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform, Discussion paper commissioned by National Health and Hospitals Reform Commission.

[38] Department of Health and Ageing (2002), The Multipurpose Service (MPS) Model, December 2002.

staff, and duplicated and inconsistent accountability requirements for the multiple funding streams which can be received by small services.

The multi-purpose service program is, therefore, a model of health and aged care service delivery that aims to help small remote and rural towns to tackle some of the challenges they face. The threshold catchment population for sustaining mainstream services will vary due to state-specific factors, distance to nearest large centre, etc. The catchment population for the multi-purpose service model varies but is generally from around 1000 to 4000.[39] It works well where:

- the population is not large enough to support separate services such as a hospital, a residential aged care service, and home and community care services;
- there is support from both the Commonwealth and state/territory governments;
- there is strong community commitment to improving the local health care;
- the existing health service providers are supportive of a multi-purpose service; and
- a multi-purpose service would be viable and sustainable under the funding arrangements.

The strengths of the multi-purpose service model are its capacity to adapt to the circumstances of diverse rural communities and provide funds flexibly across health and aged care programs according to community needs ■

We note that the strengths of the multi-purpose service model are its capacity to adapt to the circumstances of diverse rural communities and provide funds flexibly across health and aged care programs according to community needs. It offers improved access to a mix of services and quality of care, including consumer participation in services planning, plus cost-effectiveness and long-term viability of services. This support is critical in seeing the multi-purpose service through its peaks and troughs and goes beyond the impact of a single champion who may leave the area. The multi-purpose service program successfully pools multiple resources under one management structure that is 'cashed out' funding for the provision of flexible health and aged care to remote and rural communities. It receives Commonwealth funding for flexible aged care places and state/territory funding for a range of health services and infrastructure.

What we are proposing is that this type of approach be expanded in remote and rural areas. The current multiple program and funding silos would be collapsed, which means merging and pooling the funding programs, allowing local services to be reconfigured to meet local needs. The primary health care funding allocation would be based on the MBS allocation at an appropriate Australian average utilisation level, together with equivalent funding for other primary health care services.

We are proposing that the expanded multi-purpose service model would be for towns with a population catchment of up to 12,000. This model would take into account the town's proximity to larger population centres; that is, the population figure would not necessarily be fixed. It would take into account other factors, such as the distance to a larger population centre and whether there is public transport.

As examples:

1. Y is a town of 8500 within about 40 minutes drive of another larger or similar size town with complementary services. It would not necessarily require a multi-purpose service.

2. Z is a town of 12,200 and 100 km from two towns that may both benefit from a multi-purpose service. Each of the other two towns may develop some expertise that could be shared such as midwifery services and general practitioner obstetric services.

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[39] Department of Health and Ageing (2002), The Multipurpose Service (MPS) Model, December 2002.

Reform direction 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 populations; and
- expansion of the multi-purpose service model to towns with catchment populations of approximately 12,000.

9.4.4 Ensuring access by consumers in remote and rural areas

We believe a continuum of primary health care and secondary care is vital to ensure equitable access by consumers to health services in remote and rural areas. Access can be either through locally delivered services or through patient assisted travel to services that cannot be delivered locally.

The employment and distribution of specialists in remote and rural areas vary across Australia. The more remote the location, the more likely medical and allied health specialists are salaried or contracted by the regional or state health service or the Commonwealth Government's Medical Specialist Outreach Assistance Program, and not necessarily attached to a local secondary or tertiary hospital. Access to specialist services is an integral component of quality health care. Specialist outreach services should include the range of medical specialists, midwives, allied health, pharmacy and dental/oral health services that best meet local need. These services are very dependent on a robust primary health care service that can provide follow-up for the people referred.

Telehealth and telemedicine have been widely used in Australia over recent years as a means of overcoming limited access to health care, the mal-distribution of health professionals and provision of expert advice in remote and rural areas.[40] Telehealth shares many of the characteristics of successful outreach or hub and spoke arrangements. Telehealth and telemedicine are not yet used to their full potential.

■ Telehealth and telemedicine are not yet used to their full potential

Medicare has not adapted sufficiently to this form of service provision.[41] With limited exceptions, current arrangements provide that the patient be present for a consultation and that only one provider can bill for a service with the same patient at the same time. If a telehealth consultation with a metropolitan or regional specialist is arranged and the general practitioner accompanies the patient, only one of the specialist or the general practitioner can bill for this service. Funding arrangements need to change for general practitioners, other primary health care professionals and specialists, to facilitate these new ways of working. Telehealth and technologies, for example, emerging point of care testing, teleradiology, dermatology and wound care, need to be adequately funded.[42] These are complementary services that enhance and not replace the consultation. Some assist with diagnostics and involve the patient being present, and some with care planning that may not require the patient to be present in real time. At the same time, it is noted that many people prefer face-to-face interaction so the rationale and timing of use will need careful explanation.

Infrastructure is required to support information technology, communication, quality improvement, care coordination and staffing. Advances in information and communication technologies facilitate

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[40] J Wakerman and colleagues (2006), A systematic review of primary health care delivery models in rural and remote Australia 1993–2006 (Australian Primary Health Care Research Institute).

[41] J Humphreys and J Wakerman (2008), Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform, Discussion paper commissioned by National Health and Hospitals Reform Commission.

[42] CRANA (2008), Submission 73 to National Health and Hospitals Reform Commission.

new options for service delivery in remote and rural areas. For example, videoconferencing theoretically makes consultations possible over long distances and new technologies enhance the consultation and allow a range of tests and measurements to be performed remotely.

Referral and advice networks are well established in several regions of remote Australia. Developing from the original pedal radio services, to radio telephones, satellite phones and now some mobile phone coverage, regionally-organised telephone consultation services support remote area nurses and Aboriginal health workers to provide care in isolated areas. These services have grown to support general practitioners who also work in these areas, but the networks are less well organised in rural areas.

The experience in remote areas demonstrates that these networks do provide the support for, and improve the quality of care provided by, remote and rural practitioners, and should be extended to other rural areas. We heard during the consultations that there was a strong need for such services. With the increased complexity of chronic disease, with women needing to travel for maternity services, and with people opting not to travel for palliative care, a dedicated service is needed so remote and rural general practitioners, nurse practitioners and remote area nurses can call and speak to a specialist who understands their context and can link them to appropriate advice. This needs to be a separate service that is staffed by designated staff so that quality and timely advice is given. In the words of one Dubbo forum participant:

> *In our emergency department we get many phone calls from rural doctors and rural nurses at hospitals that don't have a doctor and it seems to me that we sometimes don't give good advice because we are busy doing other thing s… So what I would like to see would be a system whereby there are designated or paid doctors that can actually give advice to rural centres. The importance of having that designated or paid person is that they're expecting the call and they can give their full attention to that call … We also think that there should be a system whereby there are designated specialists that can give advice to remote doctors – whether that be the remote general practitioners or the base hospital. So if I want to talk to a neurosurgeon there may be an 1800 number, 1800 neurosurgery or 1800 cardiology or however you want to do it.* [43]

In principle, access to inpatient treatment is available for everyone without charge but this is not always provided in remote and rural areas where there may not be accessible hospital care close to a person's place of residence. This means people may need to travel, and in the words of one of the submissions:

> *Many talk about the patient journey and the problems patients have in understanding and accessing the care they require; in the case of patients from rural Australia the situation is even more complex as they will often need to travel from their local communities if they are in need of complex care that can only be provided in a tertiary referral hospital or by a city based specialist. The situation where a patient is removed from their family and social supports, has to travel many hundreds or thousands of kilometres to receive care and may be away from their local communities for long periods to undertake courses of treatment and has to foot most of the associated costs is a common one.*[44]

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[43] Health professional (3 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Dubbo.

[44] Rural Doctors Association of Australia (2008), Submission 154 to National Health and Hospitals Reform Commission.

Reform direction 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.

It has been argued that people with limited funds often choose not to travel which contributes to the higher mortality rates in remote and rural areas.[45] We know, for example, that women will often opt for the more radical treatment option of a mastectomy, as travel for chemotherapy or radiotherapy is not an option financially or for family reasons.

There has been longstanding support, currently by state/territory governments, to provide a financial contribution to patient travel and accommodation for medical specialist appointments, with significant differences between the various jurisdictions for eligibility and operation. Some groups have suggested that a uniform set of guidelines with national benchmarks should be established and monitored.[46] This is consistent with a recommendation in the recent Senate Standing Committee on Community Affairs report that '… a set of national standards for patient assisted travel schemes that ensure equity of access to medical services for people living in rural, regional and remote Australia' be developed.[47]

We are strongly of the view that primary health care in the remote or rural setting includes the principle of bringing the care to the people or the people to the care.

The issues of the importance of patients being advised about travel assistance, being easily able to complete the necessary paperwork, and not bothering to apply because both those issues have been impediments, are concerns that have been raised in consultations and submissions.[48] There is a need for a patient travel and accommodation assistance scheme with nationally consistent guidelines and user-friendly submission processes. This scheme should be funded at a level that takes account of the 'real' costs to families, and have regard to a safety net for frequent users of specialist services.

- There is a need for a patient travel and accommodation assistance scheme with nationally consistent guidelines and user-friendly submission processes

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45 National Rural Health Alliance (2005), 'Transport and accommodation assistance for health patients from rural and remote areas', Position paper.

46 For example, letter dated 29 July 2008 from the Health Consumers of Rural and Remote Australia to National Health and Hospitals Reform Commission.

47 Senate Standing Committee on Community Affairs (2007), Highway to health: better access for rural, regional and remote patients (Commonwealth of Australia).

48 For example, National Seniors Australia (2008), Submission 127 to National Health and Hospitals Reform Commission.

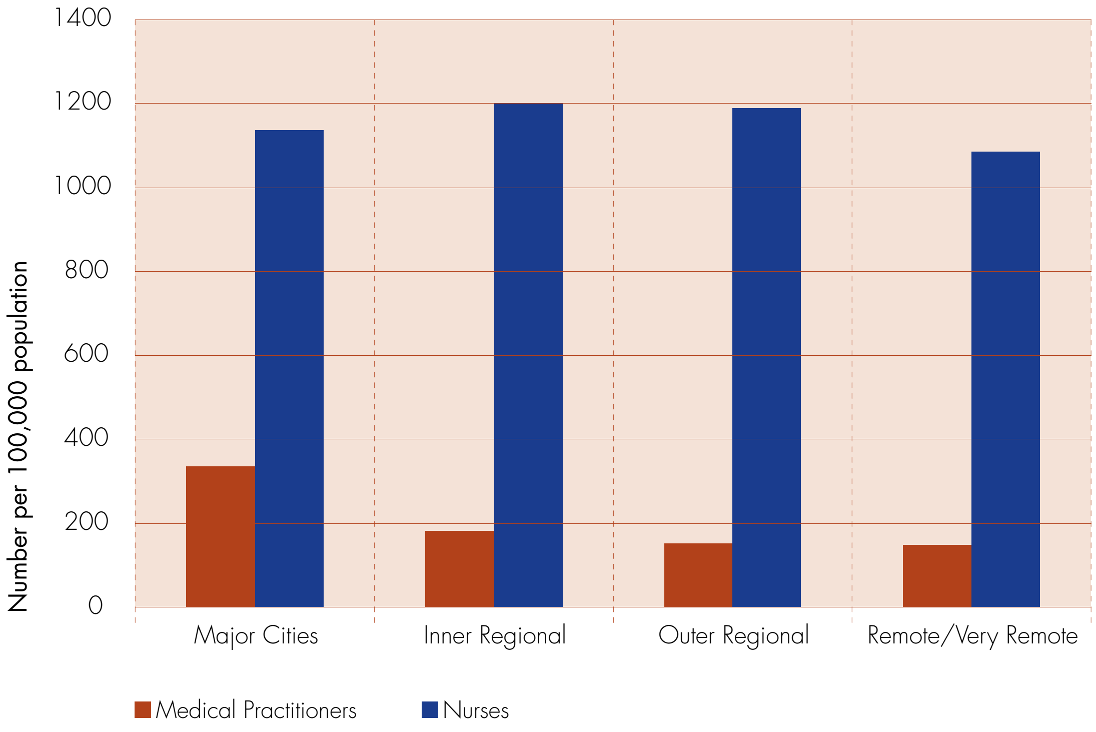
Reform direction 9.3

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.

9.4.5 Ensuring a workforce into the future

A range of strategies, including education, will help to ensure that remote and rural areas not only retain the existing health workforce into 2020, but use the workforce differently and 'grow' it. The ratio of all health workers per 100,000 population decreases with remoteness for all states and territories as well as nationally.[49] As noted in Chapter 14, the numbers of general and specialist medical practitioners, dentists and physiotherapists all decline rapidly as you move further away from major cities, while nurses are evenly distributed across regions (see Figure 9.4).

Figure 9.4: Nurses are evenly distributed across regions while the number of medical practitioners decreases with remoteness



Source: Australian Institute of Health and Welfare, Nursing and Midwifery Labour Force Survey 2005 and Australian Institute of Health and Welfare, Medical Labour Force Survey 2005.

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[49] Australian Bureau of Statistics, 2006 Census of Population and Housing.

We heard a range of solutions identified by people in the national consultations and from the submissions, including:

- extending a range of incentives beyond general practitioners to health professional groups[50], particularly those in demand;
- supporting international medical graduates, including through orientation, up-skilling, cross-cultural training and mentoring;
- supporting specialist locum programs, increased training posts across the professions with adequate support, and the continuation and expansion of outreach programs[51];
- trialling cost-shared supernumerary staff specialist positions to maintain and enhance obstetric, paediatric, emergency, surgical and anaesthetic services in regional and rural Australia[52];
- expanding capacity in rural areas – for example, through rural clinical schools and university departments of Rural Health to provide rural education and training support;
- providing internship places in rural and regional hospitals, rural primary health care and remote health services[53];
- supporting different models of maternity care so women can receive timely antenatal and post-natal care and safely have babies close to home[54];
- ensuring programs are regenerated, refreshed and renewed as workers and technology change; and
- supporting specific ongoing programs for Aboriginal and Torres Strait Islander health and community health workers.

The issue of support for students in rural placements, including through experience in working in a multidisciplinary environment, has been identified by students themselves[55] as important:

> *Key amongst these components underpinning effective regional models are multidisciplinary practice, infrastructure and financing. Multidisciplinary practice is critical and has broad implications for undergraduate, postgraduate and vocational education and training, as well as ongoing support for multidisciplinary team practice.*[56]

We know there are health workforce pressures and mal-distribution across Australia.

There is a big difference in access and levels of service provision between remote and rural areas versus regional and urban. For example, if a service is understaffed in an urban area, there is usually an arrangement that can be made to cover the services needed. This is not the case in remote and small rural areas where the service is reduced or not offered and this, in turn, impacts directly on the people who need to access those services – they go without. Single professional positions are not safe and are subject to burnout. Sustainable services are dependent on those who work in them. We need to build upon a foundation of services, commencing with those we currently have, recruiting students at the undergraduate level and continuing through to postgraduate education.

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[50] Department of Health and Ageing (2008), Report on the Audit of Health Workforce in Rural and Regional Australia (Commonwealth of Australia), plus common theme in national consultations (2008) by National Health and Hospitals Reform Commission.

[51] Royal Australasian College of Physicians (2008), Submission 315 to National Health and Hospitals Reform Commission.

[52] The Rural Doctors Association of Australia, NSW Rural Doctors Network, College of Obstetrics and Gynaecology (2008), Submission 415 to National Health and Hospital Reform Commission.

[53] NSW Medical Students Council (2008), Submission 135 to National Health and Hospitals Reform Commission.

[54] Department of Health and Ageing (2008), Improving maternity services in Australia: a discussion paper from the Australian Government (Commonwealth of Australia).

[55] National Rural Health Students Network (2008), Submission 522 to National Health and Hospitals Reform Commission.

[56] J Humphreys and J Wakerman (2008), Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform, Discussion paper commissioned by National Health and Hospitals Reform Commission.

We know that outcomes from health education in remote and rural centres are as good as in cities

We know that outcomes from health education in remote and rural centres are as good as in cities. For example, the parallel rural community curriculum program, which received a national award in 2006 for 'Best Collaboration with a Regional Focus', encourages medical students to spend one year of their training in rural general practice. The one year program has 25 per cent of Flinders University Graduate Entry Medical Program students undertaking one full year of their clinical education in rural South Australia, with 80 per cent of graduates from the program indicating they have plans for a rural medical career.[57] This principle could be applied across the professions. For example, Queensland allied health professionals are supported to access a postgraduate certificate in remote practice as a practice improvement and retention strategy. Evaluation found it to be highly valued.[58]

The Council of Australian Governments (COAG) is investing $175.6 million over four years in capital infrastructure to expand teaching and training, especially at major regional hospitals to improve clinical training in rural Australia. As COAG noted:

> *This is vital because students who train in rural areas are more likely to practice in rural Australia.*[59]

We need to focus effort on recruiting locally, making health education available, and to train people locally so they either stay or return.

Reform direction 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.

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[57] M Rann (2006), 'Riverland medical student training program recognised', press release, 27 November 2006; and LK Walters and colleagues (2003), 'The parallel rural community curriculum: is it a transferable model?', Rural and Remote Health, The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, 1–9.

[58] R Cox and A Hurwood (2005), 'Queensland Health trial of an allied health postgraduate qualification in remote health practice', Australian Journal of Rural Health, 13(3):191–192.

[59] Council of Australian Governments (29 November 2008) Meeting Communiqué.

10. Supporting people living with mental illness

Key messages

- The scale of mental illness in our community is larger than we may think and mostly emerges in adolescence or youth.
- In 2003, mental disorders were the third largest contributors to the total burden of disease and injury in Australia, accounting for over 40 per cent of disability and costing our economy about $20 billion each year.
- There is a wide range of mental disorders that will adversely affect up to half the population during their lifetime.
- It is estimated that 65 per cent of people who need mental health care go untreated. Adolescents and young adults are particularly reluctant to seek treatment or assistance for mental disorders.
- With appropriate diagnosis, treatment and support, most can recover and function normally.
- By systematically applying the current and evolving knowledge and evidence about what works, we can further significantly reduce the health, social and economic burden of mental illness.
- We need to shift mental health spending towards prevention and the treatment and supports required for those most vulnerable. This is imperative since a significant proportion of those suffering from mental illness still receive no treatment.
- Those most vulnerable are young people, as the burden of mental illness is greatest in early adulthood, and for those with a diagnosed psychotic disorder, such as schizophrenia.
- A range of social support services beyond clinical care is needed to help those suffering from mental illness – including employment support and assisted housing.
- A high proportion of those who suffer from severe forms of mental illness have a co-morbid alcohol and drug dependency, often further compounded by other chronic illnesses.
- Social exclusion is a significant contributing factor to, and often a consequence of, mental illness

Our reform directions

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.

We have a vision for mental health. In keeping with our principles to invest in prevention, recognise the health needs of the whole person, improve access to services, and for access to relate to need as opposed to ability to pay, we want to better support people with mental illness. To do this, the health system needs to make much better use of the knowledge and evidence that indicates that mental health expenditures need to be reoriented around mental health need and have a greater focus on prevention.[1] Experts believe that a modest increase (30 per cent) in expenditures could treat many more (60 per cent) people and produce a very significant (90 per cent) health gain.[2]

More than any other clinical conditions, mental health disorders require a unique approach to care provision. Currently, there is a myriad of service providers from all sectors who provide services across the age and care location continuum. Mental health services therefore require a particular focus on integration and partnership, both for the individual and the health service team. Care also needs to be provided across a continuum, allowing the consumer to enter and exit the system easily. To achieve this, additional investment and a fundamental shift in the centre of gravity of services is required – a movement to community-based and hospital in-reach.[3]

10.1 Defining and scoping mental health care

Mental health is important. It enables us to fulfil our capabilities, cope with the normal stresses of life, work effectively, and participate in our communities. Mental health problems are common. Nearly half of all adult Australians will experience a mental disorder at some point in their life.[4]

■ Mental health problems are common. Nearly half of all adult Australians will experience a mental disorder at some point in their life

Mental health problems – such as feeling down or being tense and angry – can be normal reactions to personal and social circumstances and tend not to be long lasting. However, if these problems are long lasting and/or severely affect a person's life, this might point to a mental illness, which includes a range of conditions that affect a person's thoughts, feelings, actions and mental functioning.[5] Mental illnesses may:

- be one-off problems;
- happen on a recurring basis; or
- lead to continuing symptoms.

Mental health is a major issue. The best available data indicate that, in 2003, mental disorders (problems and illnesses) represented 13.3 per cent of the total burden of disease and injury in Australia, which was the third largest group after cancers and cardiovascular disease.[6] Anxiety and depression, alcohol abuse, and personality disorders accounted for almost three-quarters of that burden. Dementia (3.6 per cent), suicide (1.8 per cent) and intellectual handicap, if included, would have taken the total to 20 per cent.

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[1] Participant (25 August 2008), National Health and Hospitals Reform Commission special interest forum on mental health in Sydney.

[2] G Andrews and the Tolkien II Team (2007), Tolkien II: A needs-based, costed, stepped-care model for Mental Health Services, Final Report (World Health Organization, Collaborating Centre for Classification in Mental Health: Sydney).

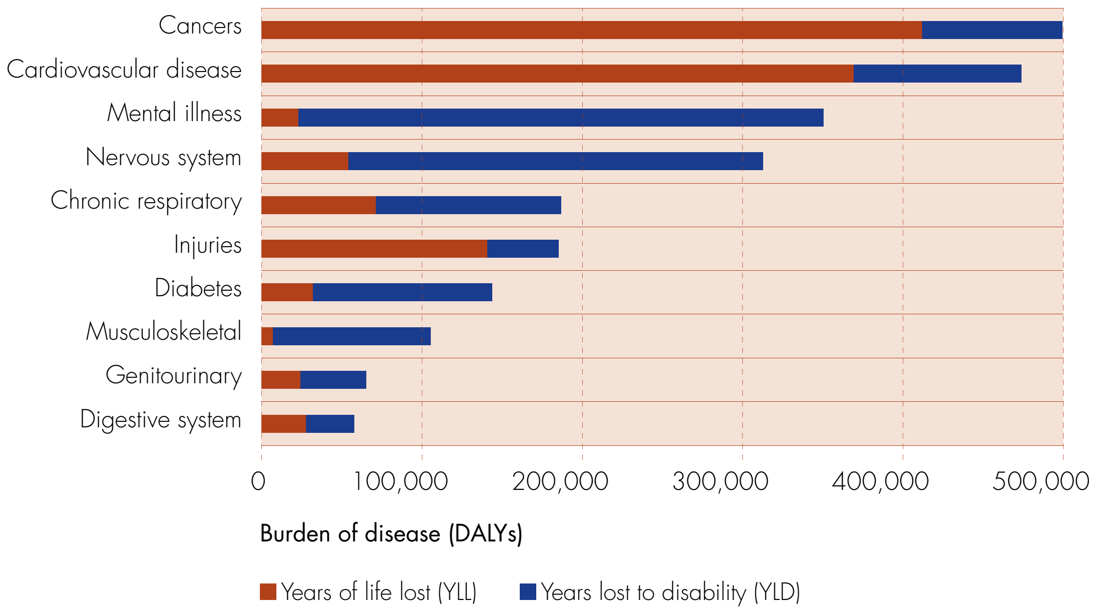
[3] Price Waterhouse Coopers (2008), Mental health funding methodologies, Roundtable Discussion paper for Australian Healthcare and Hospitals Association.

[4] Australian Bureau of Statistics (2008), National survey of mental health and wellbeing: summary of results (Australian Bureau of Statistics: Canberra).

[5] Orygen Youth Health, 'Mental health and mental illness', Factsheet, at: http://youth.wyndham.vic.gov.au/home

[6] 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).

Figure 10.1 **Mental illness is one of the major contributors to burden of disease**



1. Includes malignant and other neoplasms
2. Includes intentional and unintentional injuries
3. Disease Adjusted Life Years (years lost through death by disease, and years lost to disability by disease)
4. Mental health data is complex. Increased self-reporting rates may be due to greater willingness to report, rather than increased prevalence

Source: 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).

Of note, mental health does not make up 13 per cent of health expenditure. Presently, it accounts for approximately seven per cent of total health expenditure ($3.9 billion in 2005).[7] Further, it is estimated that only about 12 per cent of this funding is allocated to supporting people with mental illness who are living in the community.[8]

It is estimated that a majority, perhaps over two-thirds, of people with a mental disorder do not receive any treatment in any twelve month period

In 2004–05, 11 per cent of the population self-reported a current long-term mental or behavioural problem. This is a reported increase from 5.9 per cent in 1995 and 9.6 per cent in 2001.[9] Of those people with a mental-health related disability, 45 per cent report severe core-activity limitations, 29 per cent moderate limitations, and 59 per cent work or schooling restrictions. Concerningly, it is estimated that a majority, perhaps over two-thirds, of people with a mental disorder do not receive any treatment in any twelve month period.

As Australia's population ages over coming decades, the burden of, and expenditure on, mental health is set to increase significantly. Figure 10.2 illustrates how expenditure is projected to rise.

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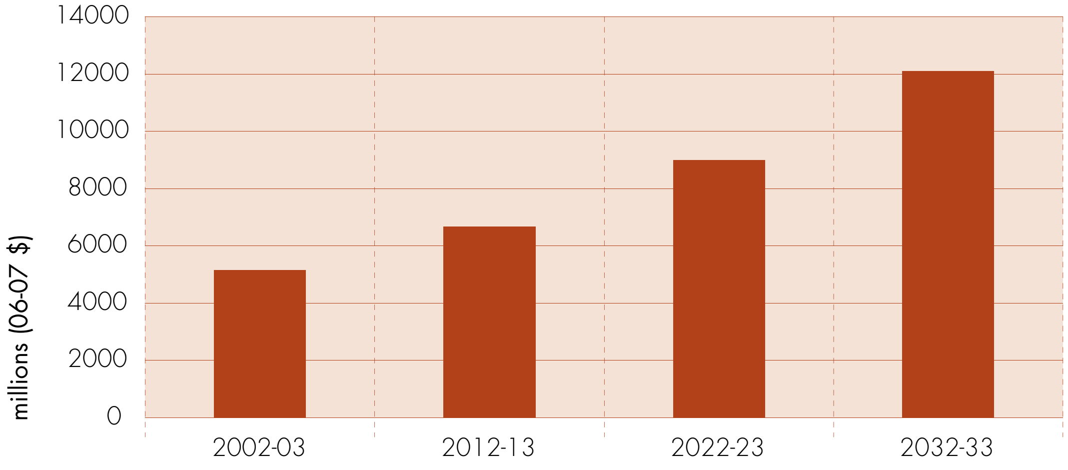
[7] National Mental Health Report (2007) (Commonwealth of Australia).

[8] Mental Illness Fellowship of Australia (2008), Submission 317 to the National Health and Hospitals Reform Commission.

[9] Australian Institute of Health and Welfare (2007), Mental health services in Australia 2004–05 (Australian Institute of Health and Welfare: Canberra).

Figure 10.2: Projected mental health expenditure



Source: J Goss (2008), Projection of Australian health care expenditure by disease, 2003 to 2033, Discussion paper commissioned by National Health and Hospitals Reform Commission.

The Australian Institute of Health and Welfare's most recent modelling indicates that, assuming current health trends and policy settings, expenditure on mental disorders alone is likely to rise by 135 per cent between 2003 and 2033. General population growth and an expected increase in the volume of services per case are the main drivers of this increase combined with a small increase in incidence and price inflation.

If the projected increase in health and residential aged care expenditure for people with dementia of 364 per cent is added into the mix, the picture looks even gloomier. Although age-standardised prevalence rates of dementia are not expected to rise, over half of the expected increase in expenditure is due to a 200 per cent increase in absolute numbers due to population growth and the ageing of the population.[10] In addition, experts are concerned about the long-term mental health implications, and broader social and economic consequences, of binge drinking and the use of illicit substances by growing numbers of Australia's young people.[11]

A variety of illnesses make up the total mental illness burden. Anxiety, depression and alcohol dependence are the most common forms of mental illness – about 18 per cent of the adult population (or 2.4 million people) experience symptoms within a 12 month period. Figure 10.3 shows the different degrees of mental illness and how it can affect people's lives.

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[10] J Goss (2008), Projection of Australian health care expenditure by disease, 2003 to 2033, Discussion paper commissioned by National Health and Hospitals Reform Commission.

[11] Participants (25 August 2008), National Health and Hospitals Reform Commission special interest forum on mental health in Sydney.

Figure 10.3: Mental illness affects different people in different ways

Prevalence	Key disorders	Typical example
Severe disability – approximately 3 per cent of the population	• *psychotic disorder* • *bipolar disorder* • *severe depression* • *severe anxiety* • *severe eating disorder*	*37 year old male who episodically hears voices. He also has severe depression and attempted suicide several times. He is unemployed, lives in public housing and is alienated from family and friends.*
Moderate disability – approximately 4 per cent	• *moderate depression* • *moderate anxiety disorder* • *personality disorder* • *substance-related disorder* • *eating disorder* • *adjustment disorder*	*21 year old male with chaotic behaviour and complex problems. He is suicidal, uses drugs heavily and experiences panic attacks. Gets into fights and was arrested for assault 4 weeks ago. He can not hold onto a job and is currently unemployed.*
Mild disability – approximately 12 per cent	• *mild depressive disorder* • *mild anxiety disorder*	*42 year old female who feels down, tearful, irritable and has withdrawn from friends over the past 4–6 months. She takes many sick days because she feels down.*

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

A much smaller proportion of the population (0.4–0.7 per cent at any given time) is affected by severe mental illness – or psychotic disorders (see Figure 10.4). However, the numbers of people affected are still significant. Each month about 58,000 adults contact mental health services because of psychosis.[12] Other research suggests that there could be up to 200,000 Australians with psychotic illnesses using hospital-based inpatient or outpatient mental health services on a recurring basis.[13]

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[12] National Mental Health Report (2007) (Commonwealth of Australia).

[13] I Hickie (2008), A new model for delivering selected mental health services in Australia, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

Figure 10.4: Understanding psychosis

The word psychosis is used to describe conditions that affect the mind where there has been some loss of contact with reality. When someone becomes ill in this way it is called a psychotic episode. Psychosis is most likely to occur in young adults and is quite common. Around 3 out of every 100 young people will experience a psychotic episode – making psychosis more common than diabetes in young people. Most make a full recovery from the experience.

Psychosis can lead to changes in mood and thinking and to abnormal ideas, making it hard to understand how the person feels. Some of the more characteristic symptoms include: confused thinking; false beliefs; hallucinations; changed feelings; and changed behaviour. There is some indication that psychosis is caused by a poorly understood combination of biological factors that create vulnerability to experiencing psychotic symptoms during adolescence or early adult life. These symptoms often emerge in response to stress, drug abuse or social changes in such vulnerable individuals.

Everyone's experience of psychosis is different and attaching a specific name or label to the psychotic illness is not always useful in the early stages. Young people experiencing a psychotic episode are not always able to understand, or willing to explain, what is happening to them. Most fear they will be labelled as 'mad'.

With appropriate treatment the majority of young people who experience a psychotic illness will recover. The earlier treatment is started, the quicker and better the recovery.

Source: Orygen Youth Health, Psychosis and young people, extracts from Factsheet: Psychosis and Young People, at: http://www.orygen.org.au/docs/INFO/fact_psychosis.pdf

Finally, it is important to note that it is common for those suffering from mental illness to have more than one pressing health problem. Dual diagnosis relates to individuals who have co-occurring mental and substance use disorders where alcohol and/or illicit drugs help bring on or exacerbate mental health problems. Dual diagnosis is a growing problem amongst Australia's youth and those affected have complex needs.[14] For example, the 2007 ABS Survey reports that one in three young people aged 16–24 years will also have a substance abuse issue, almost twice as likely as among the general population. Further, people with a mental illness are four times more likely to have another health problem such as cardiovascular disease, cancer or arthritis.

- It is common for those suffering from mental illness to have more than one pressing health problem

The mental disorder burden is not evenly spread across the population. In any 12 month period, one in five Australians between the ages of 16 and 85 years experiences some form of mental illness.[15] However, the burden of mental illness is greatest in late adolescence and early adulthood, which is when most new cases of chronic mental illnesses, such as psychotic disorders like schizophrenia, tend to emerge and have maximum impact.[16] Just over one in four (26 per cent) young people aged 16–26 years have a mental disorder, compared to six per cent of people aged 75–85.[17] It is of concern that almost 15 per cent of the younger age group (12–17 years) also experience a mental health problem in any given year.

A wide range of services beyond health services – such as social (including income) support, assisted housing and education and training services – is needed to help those suffering from severe mental disorders. These services are necessary because mental illness can be very debilitating and have profound social and economic effects beyond the pain and suffering it inflicts on individuals. Families and friends are significantly affected and are not always able to cope, and mental illness lessens an individual's likelihood of productively participating in the workforce.

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[14] Senate Select Committee on Mental Health (2006), A national approach to mental health – from crisis to community, first report.

[15] Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing: Summary of Results (Australian Bureau of Statistics: Canberra).

[16] 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.

[17] Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing: Summary of Results (Australian Bureau of Statistics: Canberra).

For example, recent studies have shown that less than 30 per cent of Australians with a disability due to mental illness participate in the workforce. This is less than half the rate of comparable OECD countries.[18]

Together, these broader factors can create a vicious cycle – with mental illness leading to isolation and reduced participation in society, which, in turn, can make mental illness worse. Consistent with this cycle, mental illnesses are more common among the unemployed and in people who have been imprisoned. In addition, many mentally ill people may end up homeless.[19]

Fortunately, public awareness and understanding of mental health has improved a little over recent years – and increasing numbers of Australians are seeking help when they need it. Yet, as we heard as part of our consultation and submission processes, there is still substantial room for improvement:

> *Mental health is chronically under-funded and resources allocated to assist people to live in the community are critically low … There is now evidence that shows [that] with best practice service models we can significantly reduce mental illnesses from becoming chronic, disabling conditions. There needs to be a paradigm shift in thinking from the focus on the biological-medical treatment to a response to needs. A change from the illness to the person.*[20]
>
> *The numbers of people with mental illness who are homeless, in prisons, living in poverty and unable to get treatment until the most acute stages of illness are testimony to the long under-resourcing of community-based mental health care and support.*[21]

10.2 Building on our strengths

The promised rhetoric of new community-based services was not, and still has not, been effectively achieved ■

Much has been done in recent years to reform Australia's mental health services, which, like those in other developed countries, were historically regarded as inadequate, inappropriate or simply not available.[22] Many people with mental illness were 'kept' in separate psychiatric hospitals until the 1980s when these hospitals were closed in favour of community-based alternatives. This change was widely accepted as more humane and progressive, although the promised rhetoric of new community-based services was not, and still has not, been effectively achieved. However, mental health services remained controversial and, by the early 1990s, governments felt compelled to act.

In April 1992, the Commonwealth and state and territory governments adopted the first National Mental Health Strategy, which committed governments to a five-year reform process aimed at improving the quality and range of mental health services available to the community. The strategy's aims were to:

- promote the mental health of the Australian community and, where possible, prevent the development of mental health problems;
- reduce the impact of mental health problems on individuals, families and the community; and
- assure the rights of people with mental illness.[23]

The strategy was significant in that it marked the first attempt to coordinate the development of public mental health services. Two other five-year plans followed. The plans led to positive changes

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[18] D Trewin (2004), Year Book Australia 2003 (Australian Bureau of Statistics: Canberra).

[19] Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing: Summary of Results (Australian Bureau of Statistics: Canberra).

[20] Mental Illness Fellowship of Australia (2008), Submission 317 to the National Health and Hospitals Reform Commission.

[21] Senate Standing Committee on Community Affairs (2008), Towards recovery: mental health services in Australia (Commonwealth of Australia).

[22] Hon Nicola Roxon MP, Minister for Health and Ageing, Grace Groom Memorial Lecture, National Press Club, Canberra, 12 June 2008.

[23] National Mental Health Report 2007 (Commonwealth of Australia).

in the structure and mix of mental health services. However, governments, the mental health sector, and the public remained frustrated at the limited extent and slow pace of change.[24]

This situation led the Council of Australian Governments (COAG) to endorse a National Action Plan on Mental Health (2006–2011) in July 2006. The plan gives impetus to further mental health reform and focuses on areas that had not progressed sufficiently under the National Mental Health Strategy.[25] The plan includes initiatives over five years to improve services for people with mental illness and their families and carers. The initiatives are designed to:

- increase clinical and health services available in the community and establish a new team approach for psychiatrists, general practitioners, psychologists and mental health nurses;
- provide new non-clinical and respite services for people with mental illness and their families and carers;
- increase the mental health workforce; and
- provide new programs for community awareness of mental health.[26]

The most well-known of the initiatives has been the Better Access Program initiative, which provides new Medicare rebates to improve access to clinical care within the community. This program, first introduced in 2006 and worth $753.8 million over five years, enables improved access to mental health care provided by general practitioners, psychiatrists, clinical psychologists, psychologists and other trained social workers and occupational therapists.[27] It aims to improve early detection, treatment and management of low and high prevalence disorders in the community and encourage health professionals to work together.

Demand for community-based mental health services through Medicare has been very strong, with expenditure running at more than three times that which was originally expected (see Figure 10.5).[28] Spending on the four major Medicare Better Access items, which together make up 87 per cent of the expenditure, had already reached $440 million over the first 20 months of the new program.

■ Demand for community-based mental health services through Medicare has been very strong

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[24] National Mental Health Report 2007 (Commonwealth of Australia).

[25] National Mental Health Report 2007 (Commonwealth of Australia).

[26] Australian Government Department of Health and Ageing, Mental Health, Council of Australian Governments National Action Plan on Mental Health (2006–2011), at: http://www.health.gov.au/internet/main/publishing.nsf/content/mental-coag

[27] Australian Government Department of Health and Ageing (2008), Commonwealth's component of the Council of Australian Governments National Action Plan on Mental Health (2006–2011), Progress Report.

[28] Mental Health Council of Australia (2008), Council of Australian Governments Mental Health Reform – Mental Health and the new Medicare Services – 2nd Report November 2006 – August 2008 (Commonwealth of Australia).

Figure 10.5: There has been strong uptake of new mental health items under Medicare by both general practitioners and psychologists

Service	Number provided	MBS benefits paid $m
Preparation of a Mental Health Care Plan by a GP	*895,544*	*135.7*
GP Mental Health consultation (20 minutes +)	*841,094*	*56.3*
Psychological assessment and therapy for a mental disorder by a clinical psychologist lasting at least 50 minutes (up to 12 planned sessions a year)	*946,224*	*108.0*
Focused psychological strategies for an assessed mental disorder by a registered psychologist lasting at least 50 minutes (up to 12 planned sessions a year)	*1,781,859*	*140.5*
	4,464,721	*440.6*

Source: Mental Health Council of Australia (2008), Council of Australian Governments Mental Health Reform – Mental Health and the new Medicare Services – 2nd Report November 2006–August 2008 (Commonwealth of Australia).

Consistent with the strong demand for the new services, the program has been described as 'the most important and practical reform in Australian mental health care in the past 15 years'.[29] Researchers have also noted that the new items will help to more than double the mental health workforce.[30] Early evaluation suggests that good results are being achieved, particularly for women with high prevalence disorders and people on low income who have had difficulty accessing mental health care in the past. We also heard during our consultations that some believe it has failed to deliver truly multidisciplinary team care because of its narrow fee-for-service funding approach. Others felt that the maximum twelve sessions were insufficient to manage many mental disorders which require often lengthy and sustained treatment and support.

Another significant mental health initiative over recent years has been the national depression initiative – better known as beyondblue (see Figure 10.6).

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[29] I Hickie and P McGorry (2007), 'Increased access to evidence-based primary mental health care: will the implementation match the rhetoric?', Medical Journal of Australia 187 (2), 101.

[30] G Andrews and the Tolkien II Team (2007), Tolkien II: A needs-based, costed, stepped-care model for Mental Health Services, Final Report (World Health Organization, Collaborating Centre for Classification in Mental Health: Sydney).

Figure 10.6: Understanding beyondblue

beyondblue, the national depression initiative, is working successfully to raise community awareness and reduce stigma and discrimination associated with depression and related disorders in Australia. Established in 2000 by the Australian and Victorian governments, beyondblue works with all governments, professional groups, research agencies, the public and private sectors, the community and individuals to address depressive illnesses.

beyondblue's national leadership role in raising awareness of depression has contributed significantly to reducing stigma and improving recognition that the illness is a serious health problem in Australia. As noted by the Hon. Jeff Kennett, the Chair:

> *In 2000, when beyondblue started out, few people were willing to speak in public about depression and their experiences, media coverage was often negative, barriers in insurance and employment were considerable and there was no national voice or advocacy service for those whose lives were affected. Australian general practitioners were not rewarded directly for providing better services and no systems for improving access to non-drug treatments were available. While we still have many challenges in front of us … we can report that major advances in all these areas have now been achieved.*

Sources: beyondblue, Annual Report 2002–2003, and beyondblue, Strategic Framework for Action 2005–2010: Opening our eyes to depression across Australia.

Many of the states and territories have also implemented a range of innovative models that have improved mental health outcomes. Some of these are discussed in the following section in the context of future reform directions.

10.3 Identifying the case for change

Our submissions and national consultation processes highlighted a number of areas where the need for reform is still significant. Such insights and ideas for reform were complemented by a number of timely official reports, including:

- the National Survey of Mental Health and Wellbeing 2007 by the Australian Bureau of Statistics (released in October 2008) – this is the first such survey in ten years; and
- Towards recovery: mental health services in Australia, by the Senate Standing Committee on Community Affairs (released in September 2008).

We believe that Australia's mental health services as currently configured are inadequate and incapable of meeting present, let alone future, needs. Indeed, in the eyes of many, the mental health system is in an ongoing state of crisis. If we want this situation to change, we need to act, and act decisively. The following discussion highlights the key challenges and the approaches that have been shown to be both effective and cost-effective.

Reforming Australia's mental health services will require some additional investment. However, this is not the most significant change that is required. The most important reform needed is to reorient mental health expenditures towards prevention and the treatment and supports required for those most vulnerable. Making this happen relies on two main things:

■ The most important reform needed is to reorient mental health expenditures towards prevention and the treatment and supports required for those most vulnerable

- Targeting resources and efforts. For example, as highlighted earlier, anxiety, depression and substance-use disorders, such as alcohol dependence, are the most common mental health problems. Together, they account for three-quarters of the mental health burden and existing services avert only a small proportion of the burden – for example, 15 per cent for mood disorders, 13 per cent for anxiety disorders and two per cent for alcohol disorders. Prevention is vital as researchers estimate that half of the burden of these three mental disorders cannot be averted by maximising the number of people being treated effectively by health professionals.[31]

- Reorganising health care services so that they represent 'stepped-care'. This is about investing initially in the least intensive and least expensive treatment in place of a more expensive but equally effective treatment that might become necessary if the first one fails.[32] In practical terms, this approach is about investing more in mental health services in both primary health care and sub-acute settings, instead of relying unduly on acute or hospital care.

If we shift mental health spending so that the health system can deliver better treatment to those in need, we can significantly reduce the burden of mental illness by 2020. This would bring broader social and economic benefits too, with increased workforce participation and reduced reliance on social security. If we let this opportunity pass and continue the existing pattern of mental health investment, we will continue to not intervene sufficiently early. This will mean the optimal level of treatment and support will not be provided when and where it is needed. By 2020, therefore, the situation is likely to be worse for people who are mentally ill and their families – and our society will be poorer for it.

10.4 Creating a better future

During our consultations we heard that improved access to primary and community health care and stronger interagency links are reform priorities for better supporting people with mental health problems. The conceptual model and framework that needs to be developed for mental health care in the future should comprise:

- community- and primary health care-based service development to promote integration of mental health care;
- recovery and rehabilitation services to reduce disability;
- better engagement with carers and consumers in planning and evaluation; and have an
- early intervention and prevention focus to mitigate illness progression.[33]

10.4.1 Improving access to mental health services

The extent of unmet need for mental health services is cause for serious reflection

Access considerations are always front and centre in health care. However, the extent of unmet need for mental health services is cause for serious reflection. All state governments have made significant increases in funding to acute or hospital-based mental health services. However, the Australian Bureau of Statistics' recent survey indicates that 2.1 million Australians with a mental health disorder over the past 12 months did not access mental health services even though they perceived they had an unmet need.[34] People with mental health problems also have a premature mortality rate 2.5 times that of the general population. This reflects poor access or usage of primary health care for physical health problems and increased lifestyle-related risk factors such as smoking, poor diet and substance use.[35]

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[31] G Andrews and the Tolkien II Team (2007), Tolkien II: A needs-based, costed, stepped-care model for Mental Health Services, Final Report (World Health Organization, Collaborating Centre for Classification in Mental Health: Sydney).

[32] G Andrews and the Tolkien II Team (2007), Tolkien II: A needs-based, costed, stepped-care model for Mental Health Services, Final Report (World Health Organization, Collaborating Centre for Classification in Mental Health: Sydney).

[33] Participant (5 June 2008), National Health and Hospitals Reform Commission special interest forum on chronic and complex needs in Sydney.

[34] Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing: Summary of Results (Australian Bureau of Statistics: Canberra).

[35] Participant (5 June 2008), National Health and Hospitals Reform Commission special interest forum on chronic and complex needs in Sydney.

It is not clear from the Australian Bureau of Statistics survey itself why these people did not access mental health services. However, such access issues exist for well-known reasons. First, the availability of mental health services differs significantly within states, regions and cities. For example, the availability of private psychiatrists in the inner suburbs of Melbourne is approximately ten times greater than in outer suburbs and rural areas.[36] The situation in Sydney is similar. A submission to the Commission pointed out that, 'Blacktown has almost 300,000 people, not far from the demographic centre of Sydney, but has only one private psychiatrist doing 3 hours per month.'[37] And, of course, access to a skilled mental health workforce lessens outside major cities.

Access problems can also exist because some individuals 'fall between the cracks' of the Commonwealth Government and state government mental health programs. For example, it is possible to have a mental illness of mild to moderate severity and complex needs and yet not meet the criteria to receive support from the state mental health system. Similarly, it is very difficult for homeless people with mental illness to access private mental health services. In addition, some people with a mental illness may be unwilling to seek help. For example, they may be concerned about the stigma of mental illness or unaware of the services available.[38]

Mental health experts have long been aware that many Australians with mental health needs are not accessing mental health services when they need them. The situation is especially serious when we consider those who are susceptible to psychosis and those who have a diagnosed psychotic disorder. The submissions made to us, and the feedback from the mental health sector, point to the pressing need for more to be done to improve access to appropriate mental health services for these especially vulnerable groups. The issues related to each group are considered in turn.

Research suggests that presently only one in four young people with a mental health problem receives professional help.[39] Strategies must be put in place to provide more integrated, community-based mental health services for children and young people which recognise their particular needs and preferences and which better engage and support families. Support for families where a parent has a mental health problem or a drug and alcohol problem also requires strengthening.

- Presently only one in four young people with a mental health problem receives professional help

> *Embedding care of people with mental health problems into the integrated primary health care system would increase access to general medical care and early intervention services and improve overall health outcomes for people with mental illness.*[40]

The Commonwealth Government has already invested around $50 million to establish the National Youth Mental Health Foundation – not to provide services, but to establish links between service organisations. It aims to deliver improvements in the mental health, social wellbeing and economic participation of young Australians aged 12–25. *headspace* is an integrated service network that focuses on early identification and treatment for young people. The benefits from this approach are profound:

> *The greatest outcome from intervening early is the reduction in the number of young people and families that experience the deepest sense of despair and enormous disruption to their lives when a young person's mental health has deteriorated to the point where they require hospitalisation.*[41]

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

[37] R Gurr (2008), Submission 223 to the National Health and Hospitals Reform Commission.

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

[39] G Andrews, S Henderson and W Hall (2001), 'Prevalence, comorbidity, disability and service utilisation: overview of the Australian national mental health survey', British Journal of Psychiatry (178): 145–153.

[40] Participant (5 June 2008), National Health and Hospitals Reform Commission special interest forum on chronic and complex needs in Sydney.

[41] *headspace* – the National Youth Mental Health Foundation (2008), Submission 88 to the National Health and Hospitals Reform Commission.

headspace involves private medical, psychological and psychiatric practitioners sitting alongside mental health and drug and alcohol workers and vocational assistance providers in one central location.[42] Funding of $35.6 million has been announced to fund *headspace*, the National Youth Mental Health Foundation, to continue its vital work on youth mental health. This will support young people across a range of areas including general and mental health, education, employment opportunities, and drug and alcohol rehabilitation.[43]

Mental health practitioners and experts support this type of model as it is youth-friendly, easily accessed and focuses on identification and appropriate early intervention for the range of mental health problems affecting young people. They would like to see enough centres established so that all young Australians can access them.[44] We support this sentiment and consider that this type of model should also incorporate sexual health services as there is growing evidence that young people do not make sufficient use of conventional sexual health services.[45]

Evaluation of *headspace* and other models which encourage engagement from children and young people at risk should be conducted to ascertain the best national approach to service delivery. Thought should be given to a model which incorporates a comprehensive, family oriented and developmental approach to service delivery. The current trend of establishing separate youth services – which split the mental health care of children and adolescents – needs to be carefully considered given the high degree of continuity of psychopathology from childhood to early adulthood. Recent studies have also suggested that web-based therapy and telephonic support with clinician supervision and interaction can be extremely cost effective and less confronting methods of treating social phobias, panic and depression.[46]

The above model provides a platform for referral to appropriate specialist services for particular disorders – for example, personality disorders, eating disorders, addictive disorders, and early psychosis, where evidence shows early diagnosis and treatment improves outcomes.

Reform direction 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.

Mental health practitioners and experts also support the Early Psychosis Prevention and Intervention Centre (EPPIC) model, which is a specialist clinical service located in metropolitan Melbourne. EPPIC involves case managers and clinical experts working closely with a young person and their family to facilitate early treatment and understanding of psychosis, and to reduce disruption to the young person. Often a young person can be successfully treated while they continue to live at home. Research has shown that this early intervention model delivers better health and social outcomes for those affected and savings to the health system.[47] The greatest savings are initially from reduced hospitalisations. We support the concept of the EPPIC model of care and consider that it should be implemented Australia-wide.

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[42] *headspace* – the National Youth Mental Health Foundation (2008), Submission 88 to the National Health and Hospitals Reform Commission.

[43] Media release, 12 December 2008, Minister for Health and Ageing, 'Supporting youth mental health: new funding and new chair for *headspace*'.

[44] Participant (25 August 2008), National Health and Hospitals Reform Commission special interest forum on mental health in Sydney.

[45] S Skinner and M Hickey (2003), 'Current priorities for adolescent sexual and reproductive health in Australia', Medical Journal of Australia 179 (3): 158–161.

[46] G Andrews (22 July 2008), Distance treatment of the girl next door. Are our therapy models flawed? Personal communication.

[47] P McGorry, E Killackey and A Yung, 'Early intervention in psychotic disorders: detection and treatment of the first episode and the critical early stages', Medical Journal of Australia 187 (7): S8.

Reform direction 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.

Beyond early intervention, mental health practitioners, carers and consumer groups all expressed significant concern to us about the social supports and organisation and culture of many hospital-based mental health services that cater to those Australians suffering from serious mental illness. These services, which are meant to work together to sustain and where necessary improve mental health, are regarded as inadequate. This situation does not meet the needs of the severely mentally ill or their families and carers – and, over time, it has worsened the mental health of many of these vulnerable people.

There are other effects too. One of the most telling has been increasing pressure on the nation's public hospitals, whether or not they have specialist mental health services, as people in crisis have nowhere else to go.

Hospitals are bedevilled by a number of well-known problems. For the severely mentally ill, emergency departments are a particular case in point. People experiencing a psychotic episode frequently turn up or are brought to public hospital emergency departments, often by the police. While these people are entitled to present to an emergency department, the care that they can receive there is not appropriate to their needs. Tellingly, experts indicate that an emergency department is one of the worst places to be for someone experiencing psychosis.[48]

- An emergency department is one of the worst places to be for someone experiencing psychosis

The situation with dedicated hospital-based mental health services is not necessarily much better. Sadly, while health professionals are very dedicated and do their utmost to assist and improve the lives of the mentally ill, it was put to us that:

> *… the culture of clinical services in hospital mental health inpatient settings is often appalling and supports a system that is about incarceration rather than therapy or recovery.*[49]

The mental health sector is committed to improving standards of clinical care for those people experiencing psychosis and agrees that conventional models of care and funding are failing badly.[50] All too often, the police are the first line of response to someone experiencing psychosis. Like other elements of health care, mental health services vary across the country as states and territories organise and implement services independent of each other. However, over time, states and territories have experimented with different models that are improving care and leading to better health outcomes. We consider that there are two models in particular related to the care of severely mentally ill people that warrant attention.

The first model involves a rapid-response outreach team that is part of hospital-based mental health services in some jurisdictions. Known as Crisis Assessment and Treatment teams, this service configuration enables those experiencing psychosis to be treated effectively away from an emergency department environment. We believe that this model should be adopted more broadly as an important first step in improving care for this patient group and alleviating some of the pressure on emergency departments. Attention will need to be given to ensuring that the safety of team members is protected by working collaboratively with law enforcement agencies. Nonetheless, the vast number of people living with a mental illness are more likely to harm themselves than others.

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[48] Participants (August 2008), National Health and Hospitals Reform Commission special interest forum on mental health in Sydney.

[49] National Mental Health Consumers and Carers Forum (2008), Submission 126 to the National Health and Hospitals Reform Commission.

[50] Participants (August 2008), National Health and Hospitals Reform Commission special interest forum on mental health in Sydney.

Reform direction 10.3

We believe that every acute mental health service should have a rapid-response outreach team for those individuals experiencing psychosis.

The second model involves prevention and recovery care, or 'stepped' care, along the lines of those provided in Victoria that are linked to hospital-based mental health services (see Figure 10.7). This model functions as a two-way bridge between primary health care services and hospital services for adults with severe mental illnesses. Additionally, this type of care can be linked to specialist and community services, including those related to drugs and alcohol, eating disorders and supported accommodation.

Figure 10.7: Making a difference to people's lives – Victoria's Prevention and Recovery Care (PARC) Model

Victoria has provided funding for PARC services over recent years and this sector is the most developed in Australia. A number of PARC facilities exist both in metropolitan Melbourne and in regional Victoria.

The Specialist Residential Rehabilitation Program in Shepparton is a partnership between the Goulburn Valley Area Health Service, which provides treatment and clinical rehabilitation services, and the Mental Illness Fellowship, which provides residential and rehabilitation support. The program, which has operated in Shepparton since 2001, enables people with a mental illness to learn and where necessary relearn living skills in a safe and supportive live-in environment.

Source: I Hickie (2008), A new model for delivering selected mental health services in Australia, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

Early intervention and community-based 'stepped' services are a major gap in our mental health system. This gap has forced many of those with mental disorders to rely on hospital-based mental health services as the first, and indeed only, option for getting help. A recent survey of mental health inpatients confirms this situation – some 43 per cent (or 1333 patients) could have been discharged if appropriate alternative services were available.[51] For those that are admitted and discharged from a hospital, there is concern that they are left largely unsupported and at risk of relapsing. If going home isn't possible straight away, the system should offer the same suite of clinical and non-clinical services as well as access to short- to medium-term accommodation options (step-down care). The same suite of community-based services should be available to manage the care of people before they become acutely unwell and require hospitalisation (step-up care).[52]

We believe that the prevention and recovery care model should also be adopted more broadly to improve health outcomes for this vulnerable group and ensure that people receive the right care in the right setting. This reform direction is consistent with our vision for enhanced sub-acute services as outlined in Chapter 5.

Reform direction 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.

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[51] Australian Mental Health Inpatient Snapshot Survey 2006, Draft Report.

[52] Mental Health Council of Australia (2006), Time for Service. Solving Australia's mental health crisis, at: http://www.mhca.org.au/

Finally, another way to improve access to appropriate mental health care is to provide better mental heath training to those in the primary health workforce, particularly those practicing in rural areas (see Chapter 3). This is vitally important since the majority of mental health services, which overwhelmingly relate to the treatment of anxiety and depression, are best delivered through primary health care. The Commission's Mental Health Special Interest Forum noted the pressing need to build workforce capacity by providing training (undergraduate and 'in-service') and support to a wider range of professionals who come into contact with people with mental illness.

Research suggests that a significant health burden associated with anxiety and depressive disorders remains untreated although both can be treated cost-effectively.[53] The economic impact of depression, in terms of foregone productivity, is estimated at over $3 billion per year.[54] To reduce this burden, researchers recommend that health care providers be encouraged to practise evidence-based medicine, even if the budgetary and organisational requirements of implementation are considerable.[55] Better education and training will provide a platform for the practice of more evidence-based mental health care.

Reform direction 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.

10.4.2 Improving access to stable housing and other community support services

As indicated earlier, social supports such as income support, assisted housing and education and training, are essential to adequately providing for the needs of those suffering from severe mental illness. Social supports help prevent episodes of mental illness and help people recover from such episodes. Improving health outcomes for those with mental disorders requires more than better access to quality health care. It requires seriously coming to grips with and providing for the multitude of needs that this group has. We heard through our submission process:

- Social supports help prevent episodes of mental illness and help people recover from such episodes

> *Those of us working in the area of mental illness know all too well that issues such as housing, employment, carer education and social security often fall 'off the radar' when it comes to health policy. With the notable and very welcome exception of the Council of Australian Government-driven funding from 2006, most funding decisions end up focussed mainly on clinical services.*[56]

We are supportive of the Council of Australian Government's work to increase investment in social support services. While our terms of reference do not extend beyond the borders of the health system, we would like to encourage all state and territory governments to provide people suffering from severe mental illnesses with stable supported accommodation linked to specialist support services along the lines of the model pioneered in New South Wales (see Figure 10.8).

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[53] G Andrews, C Issakidis, K Sanderson and colleagues (2004), 'Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders', British Journal of Psychiatry (184): 532.

[54] beyondblue (2005), Submission to the Senate Select Committee on Mental Health.

[55] G Andrews, C Issakidis, K Sanderson and colleagues (2004), 'Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders', British Journal of Psychiatry (184): 532.

[56] Mental Illness Fellowship of Australia (2008), Submission 317 to the National Health and Hospitals Reform Commission.

Figure 10.8: Making a difference to people's lives – News South Wales's Housing and Supported Accommodation Initiative (HASI)

HASI was established in 2002–03 as a joint initiative between NSW Health, NSW Housing and non-government organisations. It assists people with mental illness that need accommodation support to participate in the community, maintain tenancies and recover from their illness.

By 2007 the program was providing stable housing and accommodation support to over 1000 people with mental illness. However, the program's benefits extend far beyond housing. Significantly, evaluations have determined that the vast majority of participants required fewer visits and shorter stays in hospital due to their mental illness and nearly all had established friendships and were able to participate in social and community activities.

HASI makes a tremendous difference to people's lives. As noted by a HASI client:

> *My life would be a terrible misery without HASI. With the medication and support, I'm on top of the problems and I can enjoy life. For many, many dark years I was very suicidal all the time because I just did not enjoy being alive. I was in so much emotional and mental pain and being psychotic and too scared and taking drugs to numb it all out; something had to give. … It took ten years to get that support. I was in and out of hospital like a revolving door. Now I've got the support I need, plus the very effective medication … and now I'm quite well.*

Source: Social Policy Research Centre (2006), Housing and Accommodation Support Initiative: Evaluation, Report II

It was also suggested to us that the traditional hospital-based accommodation could be redesigned to include a set of units similar to retirement villages which:

> *… provide a peaceful environment … and where privacy would be maintained to help with recovery from acute episodes of illness. They should be located close to shops, public transport and other services like libraries and educational facilities.*[57]

Reform direction 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.

Employment is critical to good mental health

In addition, we heard that employment support for people with mental illness is managed poorly. Employment is critical to good mental health. Australia's rate of employment support for the 70 per cent of people living with a mental disorder who wish to work is very low. In comparison to other OECD countries, who manage to support 60 per cent of work participation for those with a mental disorder, Australia's rate is a low 29 per cent. Research suggests that efforts would be best placed by increasing the level of post-placement vocational support in order to help someone keep their job and advance their career.

Reform direction 10.7

We believe that governments must increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support.

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[57] K Mostafanejad (2008), Submission 498 to the National Health and Hospitals Reform Commission.

10.4.3 Reducing inconsistencies and inequities that affect mental health outcomes

There are a number of other areas where change is necessary to reduce inconsistencies and inequities that affect outcomes for people with a mental health condition. Three sets of circumstances stand out.

- The mental health needs of many older people are not well served

First, the mental health needs of many older people are not well served under the current arrangements. The intersection between aged care and mental illness is a key factor. Some nursing homes do not accommodate people with a mental illness, which causes some people to have to rely on hospital care because of a lack of alternatives.[58] This situation is unfair for the individuals concerned, who are invariably denied the aged care services they may need. This situation is also an issue for hospitals, which generally cannot care for such patients on a cost-effective basis.

As Australia's population ages, there will be a rapidly increasing need for psychogeriatric residential care services across all jurisdictions. We believe that concrete steps need to be taken to reduce this service gap and effectively meet the needs of this vulnerable group. Responsibility for taking action requires government collaboration in the short term due to the existing division in accountabilities and funding.

Reform direction 10.8

As a matter of some urgency, governments must collaboratively 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.

Second, not all Australians with mental health problems require medication. However, some who do are subject to court orders that require them to comply with treatment. Compulsory treatment orders, which are an incursion on an individual's civil liberties, are used for a wide range of reasons. However, the most common reason is to stop the recurring self-harm and chaos associated with unmedicated severe mental illness:

> *It is one of the failures of contemporary psychiatry that many patients who respond well to medication given to them when they are inpatients relapse after discharge due to not taking any further medication. Those working closely with the acute psychiatric patient in the community are often forced to stand by powerlessly as the patient deteriorates, causing damage to himself and his social milieu until such a point is reached when he is again ill enough to warrant compulsory admission and treatment.*[59]

As part of our formal consultations, we heard that Australia's states and territories do not formally recognise other jurisdictions' compulsory treatment orders. This means that those affected individuals can relatively easily get around treatment orders, which is of great concern to their families and health care providers. We believe it is time for this legal glitch to be fixed.

Reform direction 10.9

We propose that state and territory governments recognise the compulsory treatment orders of other Australian jurisdictions.

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[58] Senate Standing Committee on Community Affairs (2008), Towards recovery: mental health services in Australia (Commonwealth of Australia).

[59] P Dedman (1990), 'Community treatment orders in Victoria, Australia', Psychiatric Bulletin (14): 462.

Third, while it is important to recognise that mental health patients are entitled to privacy, we were made aware during the consultations of various sets of circumstances where this right contravened public safety, and sometimes with utterly tragic consequences. We believe that, in the interests of patient recovery and public safety, health professionals should take reasonable steps to establish where a person being discharged from a mental health facility is going and to let someone appropriate at the location know. The need for community-based, post- discharge support has already been highlighted in Reform direction 10.4.

Reform direction 10.10

We believe 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 is going; and
- someone appropriate at that location is informed.

10.4.4 Raising community awareness and consumer involvement

Research conducted in three Australian states points to relatively low levels of mental health literacy among the population

Research conducted in three Australian states points to relatively low levels of mental health literacy among the population. This lack of understanding as individuals and as communities can lead us to unnecessarily discriminate against those who are struggling with a mental health problem. For someone experiencing a mental health illness, the last thing that they need is for others to question their integrity or their value to society. This lack of community understanding also leaves those that experience mental illness isolated and fearful.

> *Mental disorders are hard illnesses to deal with but the plight of consumers is made infinitely worse by the demeaning and dehumanising attitude of the public and the ensuing condemnation and even blame.*[60]

It is perhaps not surprising then, that so many people struggling with mental health problems do not seek help to diagnose and manage their illness. We, as a community, need to change this. We need a cultural shift in our understanding and attitudes about what we can do to promote good mental health and what we can do to better help support those who may be suffering from a mental health problem.

A national comprehensive community awareness campaign combined with education for consumers, carers and health care professionals will go some way to shifting unhelpful attitudes. This requires strong leadership, greater involvement of consumers and carers in deciding what works and what does not, and more information so that we can measure how well the system is performing.[61] One suggestion made to the Commission was that a national awareness campaign could:

> *… concentrate on portraying people with a mental disorder in a positive light by using prominent society figures who also have a mental disorder as examples … to illustrate that living with a mental illness is not the end of the world but can be overcome, especially with the support of society.*[62]

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[60] K Mostafanejad (2008). Submission 498 to the National Health and Hospitals Reform Commission.

[61] National Mental Health Consumer and Carer Forum (2008) Submission 126 to the National health and Hospitals Reform Commission.

[62] K Mostafanejad (2008). Submission 498 to the National Health and Hospitals Reform Commission.

Reform direction 10.11

We propose a sustained national community awareness campaign to increase mental health literacy and reduce the stigma attached to mental illness.

Involvement by consumers is sometimes perceived as tokenistic; real engagement requires a participation framework and a genuine effort to capture and measure consumer feedback. For example, Orygen Youth Health is a strong advocate for a 'participation' approach to improving mental health care. Their programs specifically harness the input of young people and work on the basis that those who have experienced the mental health system have a stronger passion for improvement and change.[63] We advocate an approach to mental health service planning and delivery which engages consumers and carers as active participants in the process.

Reform direction 10.12

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

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[63] ORYGEN Youth Health Submission (2008), Submission 141 to the National health and Hospitals Reform Commission.

11. Improving oral health and access to dental care

Key messages

- Oral health – the condition of our mouth, our teeth and our gums – affects our overall health, wellbeing and quality of life:
  - Loss of teeth impairs eating, leading to reduced nutritional status and diet-related ill-health, particularly for children and older people.
  - Poor oral health is linked with other health conditions such as cardiovascular disease, preterm birth and low birth weight, hepatitis C, and otitis media.
  - Oral diseases create pain, suffering, disfigurement, disability and in some cases death.
- Common oral diseases such as tooth decay, gum disease and oral cancers are preventable with early detection and treatment. The absence of early intervention is costly and unproductive – estimates indicate there were 50,000 avoidable hospital admissions arising from preventable dental conditions in 2004–05.
- Many Australians suffer from poor oral health, sometimes waiting years to receive basic dental care through the public dental system as they cannot afford, or do not have access to, private dentists. Around 650,000 adults are on public dental waiting lists; the average waiting time is just over two years (27 months).
- Public dental services are under-resourced. Services provided through public dental services are predominantly for emergency care such as extractions. There is limited focus on prevention and restorative work.
- There are significant out-of-pocket costs associated with dental care. Low income households spend around 8.2 per cent of their household income on dental services.
- Good access to preventive and restorative dental care and, for those who need them, properly fitted dentures, is essential to good oral health, and is also important to maintaining good general health.

Our reform directions

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.

Australians deserve a robust dental health system

Australians deserve a robust dental health system. Improving access to dental health services was frequently raised during our consultations and in our submissions.

> *A comprehensive system is one which offers access to the full range of health services such as dentistry, allied health and community care.* [1]
>
> *I did mention around the table the state of dental health which is absolutely shocking. I have had many, many cases of a patient who has come to see me and their teeth are just rotting away and the fact is that that sort of problem tends to affect the whole health of the individual, and you find that sometimes services are being taxed simply looking after a problem that is initially actually about dental care.*[2]
>
> *Dental health promotion needs to be built into the primary and secondary school curricula at strategic points in time with class outlines that are creative and fun but with clear health messages relevant at particular ages.* [3]

11.1 Defining and scoping dental health

The oral health of Australians is varied. Some enjoy good oral health, having timely access to high quality dental care. Many others in the community suffer from poor oral health, spending excessive periods, sometimes years, waiting to receive basic dental care in the public system.

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[1] Health Consumers Alliance of South Australia (2008), Submission 90 to the National Health and Hospitals Reform Commission.

[2] Physiotherapist (8 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Geraldton.

[3] L Pagonis (2008), Submission 526 to the National Health and Hospitals Reform Commission.

All too often it is the disadvantaged who suffer the largest share of oral disease and its consequent flow-on effects on quality of life. Despite the eradication of a number of life threatening and infectious diseases, Australia has not been able to deliver equitable access to dental care.

Australia's oral health standards have room for improvement. Despite the development of a national oral health plan there is yet to be a comprehensive national approach to oral health promotion and disease prevention.

Currently, we are ranked in the bottom third among OECD countries for rates of dental decay among adults.[4] What is distressing about these statistics is that, with early detection, common oral diseases such as tooth decay, gum disease and oral cancers can be easily and cost effectively prevented. Prevention effort not only improves immediate oral health and wellbeing of an individual but also avoids further potential health complications.

- We are ranked in the bottom third among OECD countries for rates of dental decay among adults

We need a national dental health approach to both oral health promotion and disease prevention that provides equitable access for all Australians to the essential dental care services.

11.2 Building on our strengths

Australia has made some great inroads in improving oral health.

- The Australian School Dental Scheme of the 1970s and 1980s provided a foundation for oral health education and improved dental care for a generation of school aged children.
- The introduction of fluoridation in a number of metropolitan cities and other locations has significantly improved the oral health of millions of Australians.

Our current oral health system is founded on a highly skilled dental workforce, and soon to be expanded with the introduction of four new university dental schools.

- New oral health professional roles have been developed, with extensions of the scopes of practice of a number of dental auxiliaries and the introduction of dental hygienists as part of the oral health care team.
- A significant share (around 45 per cent) of our population has government-subsidised private health cover supporting them to meet some of their dental costs.

11.3 Identifying the case for change

11.3.1 Recognising the impact of oral health on wellbeing

With a healthy set of teeth, people can eat, speak and socialise without pain and discomfort or embarrassment. Oral health affects our overall health, wellbeing and quality of life and contributes to a productive workforce and society.

Poor oral health, whether dental caries (tooth decay), or periodontal (gum disease), is often accompanied by infection, discomfort, pain, and social embarrassment. The prevalence of these impacts is a silent epidemic.

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[4] Australian Council of Social Services (2006), Fair dental care for low income earners: national report on the state of dental care, at: http://www.acoss.org.au/upload/publications/papers/1562__Fair%20dental%20care_%20final.pdf.

A quarter of Australians report that they avoid eating some foods as a consequence of the pain and discomfort caused by their poor dental health and nearly one-third found it uncomfortable to eat in general.[5]

Just under one-quarter of Australian adults report feeling self-conscious or embarrassed because of oral health problems.[6] It is important to recognise that reduced self-esteem as a result of poor oral health can often impact an individual's social and community participation, and even their future employment opportunities.

11.3.2 Better oral health improves overall health

While oral disease is important in and of itself, if left untreated it can lead to further health complications, negatively impacting an individual's overall health.

A number of health conditions are associated with poor oral health. In particular, periodontal disease (gum disease) may contribute to cardiovascular disease, preterm birth and low birth weight, while diabetes directly affects the periodontium (the tissues of the gum that support the teeth). Oral disease is also associated with aspiration pneumonia, hepatitis C, HIV infection, infective endocarditis, otitis media, and nutritional deficiencies in children and older adults.[7]

Estimates indicate that there were 50,000 avoidable hospital admissions in 2004– 2005 arising from normally preventable dental conditions.[8] A failure to provide access to essential dental care, such as preventive and restorative care, has the potential to place a large and unnecessary burden on our already busy hospital systems.

11.3.3 Investing in the future through prevention

> *Common oral diseases such as tooth decay, gum disease and oral cancers are largely preventable. Early detection and interception greatly improves the outcome. If individuals can be educated as to the importance of oral health and thus avoid the serious consequences of these conditions, it would represent a worthwhile investment and achieve significant savings in the future.*[9]

The oral health of Australian children and young adults has been significantly improved over the last two to three decades through the introduction of fluoridation and the school-based dental services.[10] Young adults have half the number of teeth with decay than their parents did at the same age. Compared to other OECD countries, Australian children aged 12 years old had the second lowest number of permanent teeth with tooth decay.[11]

There is evidence that children's oral health has peaked and is now declining

However, there is evidence that children's oral health has peaked and is now declining. There has been a 20 per cent increase in the number of primary school children with tooth decay[12], and the percentage of six year old children with no decay in their baby (deciduous) teeth decreased

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[5] Australian Council of Social Services (2006), Fair dental care for low income earners: national report on the state of dental care, at: http://www.acoss.org.au/upload/publications/papers/1562__Fair%20dental%20care_%20final.pdf

[6] Australian Council of Social Services (2006), Fair dental care for low income earners: national report on the state of dental care, at: http://www.acoss.org.au/upload/publications/papers/1562__Fair%20dental%20care_%20final.pdf

[7] Australian Health Ministers' Advisory Council Steering Committee for National Planning for Oral health (2001), Oral health of Australians: National planning for oral health improvement: Final Report (South Australian Department of Human Services).

[8] Australian Dental Association (2008), 2008–09 Pre-Budget Submission (January) and Media Release (May 2008 post Commonwealth Budget), at: http://www.ada.org.au/newsroom/articles

[9] Australian Dental Association Inc (2008), Submission 324 to the National Health and Hospitals Reform Commission.

[10] J Armfield, K Roberts-Thomson and A Spencer (2003), The Child Dental Health Survey Australia 1999: Trends across the 1990s, Australian Institute of Health and Welfare Dental Statistics and Research Series No. 27 (University of Adelaide).

[11] J Spencer (2001), What options do we have for organising, providing and funding better public dental care?, Australian Health Policy Institute Commissioned Paper Series 2001–02.

[12] 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.

from 61 per cent to 56.6 per cent between 1996 and 2000.[13] A decline in access to school dental programs, and changing dietary patterns which increase the risk of tooth decay, have been associated with these changes. Another cause for concern is that the good oral health of children does not appear to carry through to adulthood.

Why should we do something about this? Poor oral health in childhood will precede a higher incidence of oral diseases, and poor general health in adulthood.

Continued investment in the promotion of good oral health for children and young adults is needed to sustain the early achievements of fluoridation and school dental services.

Australia currently lacks a universal approach to promoting oral health. Poor oral health is associated with a number of risk factors such as smoking, alcohol consumption and poor nutrition which could be addressed through oral health promotion campaigns. In considering such an approach, the Australian Dental Association emphasises that oral health promotion could be integrated into general health promotion:

> *Rather than focusing on single diseases, contemporary oral health promotion recognises that many diseases – such as heart disease, stroke, cancer, diabetes, periodontitis and tooth decay – share common risk factors including smoking, poor diet, alcohol, stress, hygiene and trauma and common health factors such as improved diet and exercise.*[14]

There are great opportunities for oral health promotion to be integrated into general health promotion, taking an approach that is not just focused on the young but has oral health promotion built in across the life course. Suggestions received through submissions were to include oral disease screening questions into medical health checks, or that childhood obesity programs, as well as focusing on physical activity levels, should also consider dietary patterns and nutrition. Dental decay is a diet-related disease and therefore these programs could also incorporate a focus on the reduction of drinks and foods with extrinsic sugars and high acids.

One example where oral health has been linked to other campaigns is the National Health Warnings Campaign for smoking. One of the graphic warnings is that mouth and throat cancer is caused by smoking. 'The concept for the "Mouth Cancer" media campaign was tested with smokers of all ages and from different backgrounds. They found the proposed scene with a woman with mouth cancer talking to have a strong impact.'[15]

11.3.4 Providing access to dental services for all

Access to dental care is through private dentists or the public dental system. The public dental service has two main programs: school dental services; and public dental services for adults which are means tested. Approximately 30 per cent of all Australian adults are eligible for public dental care.

One in four Australian adults has 'unfavourable' access to dental services. That is, they visit a dentist less than once a year, usually for a dental problem rather than prevention, and usually do not see the same dentist. Those with unfavourable access to dental services are:

- almost four times as likely to have a tooth extracted than those that have favourable access to dental care; and
- half as likely to receive preventive care relative to those that have favourable access.[16]

■ One in four Australian adults has 'unfavourable' access to dental services

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[13] 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.

[14] Australian Dental Association Inc (2008), Submission 324 to the National Health and Hospitals Reform Commission.

[15] National Health Warnings Campaign, Questions & Answers, at: http://www.quit.org.au/downloads/Health-Warnings-Mouth-Cancer-Backgrounder.pdf

[16] 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.

The significant out-of-pocket cost associated with dental care has created access issues for many of the most disadvantaged in our community, leaving them to bear a disproportionate share of oral disease. Avoiding and delaying dental care due to cost is worst among:

- low income people – 46.6 per cent of people on incomes less than $20,000 avoid or delay dental care;
- health Care and Concession card holders – 44.0 per cent of cardholders avoid or delay dental care;
- people without private health insurance – 42.7 per cent of non-insured people delay/avoid dental care; and
- Aboriginal and Torres Strait Islander peoples – 37.9 per cent delay/avoid care.[17]

Compared to their expected use of dental services based on their population share, the lowest income group in the population use dental services at only 49 per cent of the recommended level. In contrast, the highest income group uses dental services at 172 per cent of the levels recommended by dental experts.[18]

Such results come as no surprise, given that one in every twelve dollars of all household spending by low income households is spent on paying for dental care. This accounts for approximately 8.2 per cent of household spending among the lowest income households.[19]

The high cost burden, coupled with the much lower use of dental services by low income households, highlights the significant cost and access barriers to dental care.[20]

There are about 650,000 adults on waiting lists for public dental services across all Australian states and territories

Eligibility for public dental services is patchy. The fortunate few who are eligible for public dental services are left in line to wait. Current estimates indicate that there are about 650,000 adults[21] on waiting lists for public dental services across all Australian states and territories. While the average waiting time for adults to access public dental services across Australia is 27 months[22], it has been reported that some people can wait as long as five, six or seven years.

11.3.5 Making oral health part of the broader health system

> *Dentistry is currently perceived as an ancillary health service rather than a core health service. The lack of integration of dental services with general health services at all levels, including education, service, insurance, administration and government, has resulted in an overall decrease in the health status of the population.*[23]

The 'separateness' of oral health from general health is embedded in the current organisational and funding arrangements for health. It has rightfully been said that 'public dental care, as a means-tested residual program, is a torn and tattered safety net, characterised by institutionalised scarcity and harsh rationing of personal dental treatment'.[24]

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[17] 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.

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

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

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

[21] Australian Dental Association (2008), 2008–09 Pre-Budget Submission (January) and Media Release (May 2008 post Commonwealth Budget), at: http://www.ada.org.au/newsroom/articles

[22] Australian Dental Association (2008), 2008–09 Pre-Budget Submission (January) and Media Release (May 2008 post Commonwealth Budget), at: http://www.ada.org.au/newsroom/articles

[23] Association for the Promotion of Oral Health (2008), Submission 421 to the National Health and Hospitals Reform Commission.

[24] J Spencer (2001), What options do we have for organising, providing and funding better public dental care?, Australian Health Policy Institute Commissioned Paper Series 2001–02.

One consumer pithily phrased this as:

> *If you've got a boil on your bum, it's covered by Medicare; if you've got a boil on your gum, it's not!*[25]

While 'general health' services have been subsidised to ensure universal access with shared responsibilities across Commonwealth and state governments for medical and public hospital services, 'oral health' services have been means-tested and inadequately funded.

11.3.6 Sharing the burden of dental costs

The landscape of who pays for dental services is very different to our universal health programs (see Figure 11.1).

Figure 11.1: Individuals pay much higher shares of the cost for dental services than for public hospitals, doctors and medicines

	Service	Commonwealth	State governments	Private health insurance	Individuals	Other	Total
Universal	*Public hospitals*	*39.9%*	*53.2%*	*1.7%*	*0.5%*	*4.7%*	*100%*
	Medical services	*78.3%*	*0%*	*4.2%*	*12.0%*	*5.6%*	*100%*
	Pharmaceuticals	*83.0%*	*0%*	*0%*	*17.0%*	*0%*	*100%*
Dental	*Dental services*	*9.2%*	*9.0%*	*14.3%*	*67.3%*	*0.2%*	*100%*

Source: Australian Institute of Health and Welfare (2008), Health Expenditure Australia 2006–07, Table A3, current prices 2006–07 expenditure.

Governments contribute less than 20 per cent of all spending on dental services; health insurers contribute about 14 per cent; and individuals bear two-thirds of the total cost directly as out-of-pocket payments.

- Governments contribute less than 20 per cent of all spending on dental services

In fact, existing Commonwealth Government spending on dental health services is largely directed to those in our community who have relatively good access to dental services – privately insured individuals. In 2006–07, 79 per cent of the Commonwealth's spending on dental health occurred through the private health insurance rebate, accounting for $414 million of the Commonwealth's $528 million expenditure on dental health services.[26]

11.4 Creating a better future

One of our most important challenges is improving access to dental health services. There are major inequities in who is able to access dental care, who has reasonable oral health status, and who pays, and how much, for dental services.

The separation of oral health from general health is not compatible with our principle of comprehensiveness. We have indicated in this principle that the health and aged care system should be able to meet the entire range of people's health needs over their lifetime. Of course, this must include what is happening in their mouths.

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[25] Audience member (20 May 2008), Pulling teeth, SBS Insight episode, at: http://news.sbs.com.au/insight/episode/index/id/21

[26] Australian Institute of Health and Welfare (2008), Health Expenditure Australia 2006–07 (Australian Institute of Health and Welfare: Canberra).

Reform direction 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.

In developing 'Denticare Australia', we have been conscious of several critical situational factors in deciding how best to shape, organise and finance such a scheme.[27]

First, most current spending on dental services goes toward restorative and preventive care. The costing that we have commissioned indicates that a new dental scheme covering restorative, preventive and diagnostic dental services, together with extractions and dentures, would equate to almost 80 per cent of total current spending on dental services. The remaining 20 per cent of current spending is directed towards what might be considered 'elective' dental care, including crowns, bridges, implants and services such as cosmetic and laser dentistry.[28]

We believe that, given the huge gaps in access for many people to any dental health services, the priority focus of 'Denticare Australia' should be on prevention, early diagnosis and management, and restoration of function (including through the supply of dentures). We further note that the approach we have taken elsewhere in this report, of requiring health services to be evidence-based and provided as cost effectively as possible, should apply equally to the proposed scheme for dental services.

Second, we have been strongly influenced in our design of 'Denticare Australia' by the dominant role of private dentists in providing most dental services and by the relatively high uptake of private health insurance for dental care. About 45 per cent of the population currently have private health insurance for dental services; a further 35 per cent of the population do not have private health insurance but use the services of private dentists. Only 20 per cent of the population neither have private health insurance nor use private dental services, and instead rely solely on public dental services (see Figure 11.2).

Private dental services and the continued use of private health insurance for dental care must remain as significant components of a new dental scheme ■

This is not a 'greenfields' situation – in other words, we are not starting from scratch. Accordingly, we believe that private dental services and the continued use of private health insurance for dental care must remain as significant components of a new dental scheme.

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[27] The NHHRC has commissioned two interrelated papers that helped shape the formulation of our reform directions for dental health services. These two papers, available on our website, are: Improving oral health and dental care for Australians (J Spencer and J Harford); and Costing a social insurance scheme for dental care (PriceWaterhouseCoopers).

[28] We note that additional work will be required to reach agreement on the scope of services that would be eligible for coverage under the proposed universal scheme. Preliminary estimates are included in the PriceWaterhouseCoopers paper.

Figure 11.2: There is currently strong use of private dental insurance and private dentists

		Services Accessed	
		Private practitioner	Public scheme
With dental health insurance (Current = 45%)	*Non School Age 81% of insured*	*35%*	*1%*
	School Age 19% of insured	*5%*	*3%*
Total with dental insurance		*40%*	*5%*
No dental insurance (Current = 55%)		*35%*	*20%*
Total dental services in sector		*75%*	*25%*

Source: PriceWaterhouseCoopers (2008), Costing a social insurance scheme for dental care, Supplementary report, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

Reform direction 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.

The principle is to use an increase in the Medicare Levy as the most equitable approach to raising the additional funds required to achieve universal coverage. The extra Medicare Levy funding would be combined with all existing funding by governments (Commonwealth and states) to create the funding pool used as the basis for the scheme.

How this would operate at the level of individuals and families is that:

- Everyone eligible to pay the Medicare Levy would pay an extra 0.75 per cent of taxable income towards a universal dental scheme 'Denticare Australia'.
- This levy would replace existing premiums paid for private dental health insurance covering preventive, diagnostic and restorative services and most out-of-pocket costs for these dental services.
- Everyone, regardless of whether they have private health insurance for other health services, could choose either a dental health plan from a private health insurer or to rely on expanded public dental services funded by 'Denticare Australia'.
- For people choosing a private dental health plan, 'Denticare Australia' would pay the premium for that plan for them from the new funding pool. At the outset, the premium payment would be set at a level so that individuals and families were covered for about 85 per cent of the current costs of private dental services covered under the package.
- 'Denticare Australia' would also provide additional funding for public dental services to expand their availability for people choosing to rely on them. There would be no out-of-pocket costs for people using public dental services; however, there might still be some waiting times to access care.

The premium paid by 'Denticare Australia' to a private health insurer for each person choosing their dental plan would be 'risk adjusted' – that is, it would be higher for people likely to require more dental services and lower for people likely to require fewer. Private health insurers could still offer coverage for 'elective' dental services such as orthodontics, cosmetic and laser dentistry that are not covered by 'Denticare Australia'.

Reform direction 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.

In addition to our proposals relating to the financing of 'Denticare Australia' to provide universal access, we believe that there is a range of other issues that needs to be tackled to improve oral health status.

It has been estimated that a full residency program would increase the public dental workforce by over 50 per cent

Our fourth reform direction recognises the need to expand the clinical experience and training of the dental sector workforce. We support the concept of a change to the current education of the dental workforce through the introduction of a dental education and residency program, an idea that was advanced in several submissions.[29,30,31] This program would provide a solid grounding for new graduates prior to their registration in the care of complex public dental patients. In addition to routine dental care, the residency program could include the development of competencies in geriatric dentistry, special needs dentistry and dentistry for the intellectually disabled. It has been estimated that a full residency program would increase the public dental workforce by over 50 per cent.[32]

Reform direction 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.

Good oral health should begin at an early age. Our fifth reform direction is aimed at continuing to improve young people's oral health through school dental programs with a focus on both the provision of dental services and oral health education programs.

As outlined earlier, there has been a significant improvement in the oral health of young people over the last 30 years, with young adults having better oral health than their parents, reflecting their exposure to fluoride in drinking water and toothpaste, and a period of high coverage by school dental services.[33] However, this improvement appears to have levelled out and is now declining.

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[29] School of Dentistry, University of Adelaide (2008), Submission 175 to the National Health and Hospitals Reform Commission.

[30] The Association for the Promotion of Oral Health (2008), Submission 421 to the National Health and Hospitals Reform Commission.

[31] Australian Dental Association Inc (2008), Submission 324 to the National Health and Hospitals Reform Commission.

[32] J Spencer and J Harford (2208), Improving Oral Health and Dental Care for Australians, Discussion Paper commissioned by the National Health and Hospitals Reform Commission

[33] School of Dentistry, University of Adelaide (2008), Submission 175 to the National Health and Hospitals Reform Commission.

Nationally there has been a 20 per cent increase over the last 10 years in the number of primary school children with tooth decay.[34]

We were told in the submissions received about the limited access in many states to dental care under school dental programs. We believe that school dental programs are well placed to diagnose, treat and promote good oral health, and that these efforts must be sustained to reduce the level of oral diseases in adulthood.

- We believe that school dental programs are well placed to diagnose, treat and promote good oral health

Reform direction 11.5

We propose the national expansion of the pre-school and school dental programs.

Our final reform direction supports increased funding for oral health promotion. We believe that oral health promotion is an essential first step in maintaining and improving oral health, and in improving overall health and wellbeing immediately and in the future – prevention is better than cure.

As outlined earlier, oral diseases such as tooth decay, gum disease and oral cancers are largely preventable, sharing a range of risk factors such as smoking, poor diet and alcohol consumptions with many diseases. These factors underpin the need for an improved oral health promotion program. We believe the positive effects of an oral health promotion campaign would be compounded if oral health messages were also integrated into other health promotion campaigns, as has been done for smoking.

Reform direction 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.

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[34] 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.

DRIVING QUALITY PERFORMANCE

BETTER USE OF PEOPLE, RESOURCES, AND EVOLVING KNOWLEDGE

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12. Strengthening the governance of health and health care

Key messages

- There is widespread dissatisfaction with the fragmentation of services on the ground and that the system doesn't work together as a whole. This is often seen as being due to problems of governance and the 'blame game'.
- The public does not find it easy to know which government to hold to account for their access to health care and the quality of that care.
- There is a mismatch between which government raises the revenue and which government spends it. This creates complexity in the management of the health system, and makes national leadership more difficult.
- No one government has an understanding of, or exposure to, the health system as a whole.
- There are insufficient opportunities for people and their families to participate and have their views heard in the health system.
- Separate funding streams distort priorities and cause problems in service delivery, especially in primary health care.

Our reform directions and options

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.

12.1 The $94 billion dollar question

Governance – or who should 'run' the health system – is without a doubt the single most controversial issue we have been asked to tackle

Governance – or who should 'run' the health system – is without a doubt the single most controversial issue we have been asked to tackle.

It is an issue on which people hold very strong, and sometimes, opposing, views. In many of the discussions we had around the country, the issue of governance was the not very well-hidden 'elephant in the room'. It could equally be labelled the '$94 billion dollar question': Who should be responsible, and how, for the $94 billion we spend annually on health services across Australia?

We begin this chapter by presenting some of the diversity of views we heard and read on how to improve the governance of the Australian health system.

12.1.1 What do individual consumers and health professionals think?

First, we present some of the views we heard from consumers and frontline health professionals during our 'listening tour' across all states and territories (see Figure 12.1). Many consumers – or users of the health system – simply wanted someone to 'fix the system', whether that related to public hospital waiting lists or lack of access to health services in rural areas. People working in the health system talked about problems with the level of bureaucracy and cost-shifting between governments. While some people were nervous about giving greater power to the Commonwealth Government, many people blamed problems with public hospitals on state governments.

Without being specific on the detail, a strong message we heard from many consumers and health professionals was a desire for 'national leadership' coupled with 'local decision-making' or 'local flexibility'. The 'one health system' idea meant different things to different people. For some people, it was akin to the 'railway gauge' concept: everyone should have access to the same new cancer drugs or affordable patient transport, and the health system should be the 'same', no matter whether you lived in Canberra or Coober Pedy. For other people, 'one health system' meant simplifying and streamlining the many different health 'programs' so that people could get the services they needed, without having to navigate the maze of Commonwealth and state-funded health services. For yet other people, one health system meant being assured that someone – most often viewed as the Commonwealth Government – would take responsibility for adequately funding the health system. We return later to the concepts of 'national leadership' and 'local flexibility'.

- A strong message we heard from many consumers and health professionals was a desire for 'national leadership' coupled with 'local decision-making' or 'local flexibility'

Figure 12.1: The community has many views on how the health system should be governed

In our consultation meetings across the country, one of the most commonly discussed issues was how the health system should be governed.

Some people were all for abolishing the role of the states and territories:

> *National health system – we need firstly to reduce the bureaucracy. The best way to do that is to abolish the state health ministries and departments and to have a national health system. (Health professional, Dubbo, 3 June 2008)*

Others were sceptical about options involving more decisions being made in the national capital:

> *I'm a nurse, we're sick of being told over here by Canberra what to do and what's best for us … without any consultation. We are sick to death of hearing things from Canberra. Local issues are not considered when funding is offered. You have people sitting in Canberra saying 'yes you can have this grant' or 'no, you can't' never having seen Geraldton and the resources or the distances here. (Nurse, Geraldton, 8 July 2008)*

Some proposed less sweeping changes, looking for adjustments to existing arrangements that would make responsibility and accountability clearer:

> *I think that I'd just like to really see that there's a clear responsibility for health delivery between the Commonwealth and the states. For example, that the Commonwealth take on primary care and make it work for all people across Australia, rural remote Australia and that the states do have full responsibility for hospitals, emergency, rehabilitation. And that there are some solutions for the connection between those two systems made that are fairly clear so that basically everybody knows how, from the people in the street through to the top bureaucrats, what the system is and who's got responsibility for it. (Physiotherapist, Cairns, 17 June 2008)*

The most consistent view was the desire for a single national health system:

> *… could we please have a national system? I'm really very, very well aware of the amount of duplication that happens with Commonwealth and state. There's all this reporting and evaluation, cost shifting and it's a nightmare and it drains money from the system. (Health professional, Hobart, 28 May 2008)*
>
> *I think if we did away with one level of administration we would save so much money and seeing as budget seems to be the top priority in running hospitals. I think there is too much administration and not enough health care, acute health care. (Consumer, Dubbo, 2 June 2008)*

12.1.2 Other views on governance

While many consumers and health professionals wanted 'change', they did not necessarily have well-developed views about how to get from 'here' to 'there'. Working out how to 'fix' the governance of the Australian health system is, after all, neither most people's day job, nor their main recreational hobby.

We commissioned some experts to prepare a discussion paper that examined different options for reform of Commonwealth and state governance responsibilities for the Australian health system.[1] We also received many submissions from health sector peak organisations, professional colleges, state governments and academic experts that offered ideas on both the diagnosis and the prognosis for health system governance. We turn now to some of these views.

Some major stakeholders are advocating quite fundamental reforms to how our health system is governed

- First, it is obvious that some major stakeholders are advocating quite fundamental reforms to how our health system is governed.

The Australian Health Care Reform Alliance proposed that a major element in health system reform should involve the concept of 'funds pooling', arguing that:

> *It is widely believed that pooled funding would help address accountability and equity for patients and providers, and provide greater equity of access. It also has the capacity to result in greater equity between regions and population groups. The reduction in the number of health funding sources through pooling also has the capacity to lower administrative costs and thus reduce per capita health care expenditure or free up some of the existing expenditure for new purposes.* [2]

The alliance identified six different models by which funds could be pooled. Two of these options involved assumption of full financial responsibility for the health system by either the Commonwealth Government or the state and territory governments. The other four options involved different combinations of pooling or combining funding at the regional level or for specific population groups or on a voluntary basis. However, the Australian Health Care Reform Alliance does not have a preferred model, instead suggesting that further examination of the range of models is warranted.

Other groups see 'funds pooling' as a transitional step towards the ultimate goal of the Commonwealth assuming full financial responsibility for the whole health system. For example, the Chamber of Commerce and Industry of Western Australia argues that:

> *Full funding responsibility should be transferred to the Australian Government as the single public funder of health services. As a transitional arrangement, Chamber of Commerce and Industry supports the establishment of a joint Commonwealth/Western Australian Health Commission through which Commonwealth and State health funding could be pooled.*[3]

But some groups see the concepts of 'funds pooling' and 'Commonwealth responsibility' as mutually exclusive. The Royal Australasian College of Surgeons argues for clear accountability and no 'cross-over' or pooling of Commonwealth and state funds for health services as follows:

> *The College has long been a supporter that all the health system should be fully federally funded with the responsibility and accountability residing with the federal minister. The College and a number of its associated specialist societies still strongly believe that only by having one funder will accountability and responsibility be substantially improved.*

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[1] J Dwyer and K Eager (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.

[2] Australian Health Care Reform Alliance (2008), Submission 446 to the National Health and Hospitals Reform Commission.

[3] Chamber of Commerce and Industry of Western Australia (2008), Submission 62 to the National Health and Hospitals Reform Commission.

> *However, the College recognises the constitutional and political challenges of this. Whatever the model achieved, there needs to be minimal cross-over between funding streams to achieve optimal care.*[4]

- There are quite different views about which health services or funding streams should be picked up by the Commonwealth

While many stakeholders support a stronger role for the Commonwealth Government, there are quite different views about which health services or funding streams should be picked up by the Commonwealth. The starting point for most groups (which was also reflected in the views of ordinary Australians who attended our community and health professional consultations) was for the Commonwealth to take responsibility for public hospitals. But some stakeholders wanted an even more expanded role for the Commonwealth. For example, Gavin Mooney argued that:

> *There is so little sense in taking over the hospitals nationally and even less in taking over only the poorly performing ones without taking over the whole health service. There is a very good case for the Commonwealth financing and running the whole health service.*[5]

Others go even further. Ian McAuley and John Menadue argue for a 'single national insurer' covering not only all publicly-funded health services (including public hospitals, medical services, community health services) but also all privately-funded health services (such as private hospitals).[6]

These views remind us that when most people talk about the Commonwealth becoming the 'single funder', they are actually using the term to mean 'single public funder' with a continued role for a complementary private health insurance sector. We have adopted this distinction in this chapter, and our discussion of governance options is about the roles of Commonwealth, state and territory governments for publicly-funded health services.

Some stakeholders see potential for benefits from greater 'blurring' of the distinction between 'public' and 'private' health services, linked to major governance reforms. Catholic Health Australia believes that the Commonwealth should take on responsibility for the whole health system, but that:

> *Having responsibility for financing the health care system does not mean the Commonwealth would run services – in our view services are best delivered by the organisations that can provide the most efficient, highest quality and cost-effective services whether they are government or non-government organisations. The significant role played by the private sector in both the provision and financing of health services in providing additional choices and innovation needs to be acknowledged.*[7]

Catholic Health Australia goes further in offering to participate in trialling direct funding by the Commonwealth Government of funding public hospitals.

While there is thus a strong groundswell of interest (and some partially developed proposals) for major governance reforms, some stakeholders hold equally strong views about the risks associated with changing how we govern the Australian health system.

Chief among these is the Australian Medical Association (AMA) who urged us to apply the 'first, do no harm' principle in our deliberations on health reform. The AMA cautioned about the 'considerable risk' associated with 'big bang' reform.

> *The AMA does not believe that 'big bang' reform in Commonwealth/State health financing is feasible. There is too much inertia and too strong a vested interest on the part of governments in the system as it is. A major change in responsibilities would have a high chance of raising complex and hotly contested issues such as a redistribution of tax powers. We expect that these issues will remain insoluble. There is plenty of untapped potential for incremental reforms that could lift system performance and improve patient outcomes.*

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[4] Royal Australasian College of Surgeons (2008), Submission 406 to the National Health and Hospitals Reform Commission.

[5] G Mooney (2008), Submission 275 to the National Health and Hospitals Reform Commission.

[6] I McAuley and J Menadue (2007), A health policy for Australia: Reclaiming universal health care, Centre for Policy Development, at: http://cpd.org.au/category/all-articles/health/reclaiming-universal-care

[7] Catholic Health Australia (2008), Submission 57 to the National Health and Hospitals Reform Commission.

> *However, as we have noted …, efficiency gains cannot solve the under-resourcing of the sector. More funding is needed and the Commonwealth government needs to pick up the ball it previously dropped.* [8]

The AMA further noted its concerns that one of the risks of 'big bang' governance reforms is that 'political consensus will be possible only around very limited and poor quality reforms'.

Similar views were echoed in some of our other submissions. Other elements of these concerns related to: the potential for governance reform to become the 'only game in town'; that reform needed to focus strongly on better organisation and delivery of health services for people on the ground; and that governance reform did not equate to a single 'magic bullet' solution for all the problems with the health system.

For example, the South Australian Health Department argued that:

> *Whilst a clear separation has inherent value it does not seem to take account of the complexity of health care and the myriad of providers in place. Separating roles too much may not resolve the challenges of providing integrated service. Regardless of how respective roles are divided up, there remains an integration issue between those different roles. There may be nothing wrong with having shared roles and responsibilities; the important factor that needs to be focused on is how to provide seamless, person centred care across the service continuum.* [9]

Professor Stephen Leeder cautions against building solutions that start from the problems of blame and cost shifting. He further suggests that:

> *At a time when most developed nations are looking at ways to decentralize and 'federalize' health services we should be wary about easy centralizing fixes.* [10]

And Paul Gross argues that reforms in other areas should take priority over governance reforms:

> *The Commission should not waste its time debating 'big bang' reforms that require a revolution. Long before 2020, we can fix the current messiness by new financial incentives, use of modern information technology, and alternatives to the Council of Australian Governments as a major change agent.* [11]

There is not yet consensus on a 'single solution' to how to improve governance of Australia's health system to ensure better health outcomes for people

In summary, our digest of the many views we heard through consultations and submissions was, not unsurprisingly, that there is not yet consensus on a 'single solution' to how to improve governance of Australia's health system to ensure better health outcomes for people.

Where to from here?

Given the complexity of these issues, and the diversity of views on both the problems and the solutions, we have decided that the most valuable contribution we can make in this, our Interim Report, is to clearly present the issues and choices on governance reform. This will allow a more well-informed community debate about the $94 billion dollar question of who should 'run' our health system.

Accordingly, in the remainder of this chapter, we:

- describe the critical features of existing governance arrangements and outline some of the factors that will need to be considered in any major reform of health system governance (Section 12.2);
- identify some important functions and roles that we believe would benefit from national leadership (irrespective of how the health system is governed) (Section 12.3);

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[8] Australian Medical Association (2008), Submission 445 to the National Health and Hospitals Reform Commission.

[9] South Australia Health (2008), Submission 458 to the National Health and Hospitals Reform Commission.

[10] Menzies Centre for Health Policy (2008), Submission 420 to the National Health and Hospitals Reform Commission.

[11] P Gross (2008), Submission 448 to the National Health and Hospitals Reform Commission.

- identify some approaches to enhancing local flexibility and strengthening public voice (irrespective of how the health system is governed) (Section 12.4); and
- describe three major options that we believe represent genuine opportunities to improve how our health system works for people (Section 12.5).

12.2 Critical features of the governance of the Australian health system

12.2.1 Government roles in the Australian context

■ In Australia, responsibility for health care is divided between two levels of government

In Australia, responsibility for health care is divided between two levels of government, which each have quite different approaches to funding, and quite different relationships to providers. (We note that while local government has an important role in providing health, community and aged care services, the discussion in this chapter focuses on the roles of the Commonwealth and state and territory governments.)

While the majority of funding of health services in Australia is public, the majority of expenditure on health services goes to non-government organisations and professionals in private practice operating in a regulated, competitive market.[12] The exception is that most state-funded services are provided by government entities – in particular, most public hospitals and many community health services.

In contrast, virtually all health and aged care services supported directly by Commonwealth funding are provided by non-government entities, most of which are private businesses (for example, medical practitioners in private practice, local chemists, pathology and radiology companies, and aged care). The same holds true for Commonwealth indirect support for health care through the private health insurance rebate: Commonwealth funding support mostly flows to support access by consumers to private providers of health services.

Put another way, states and territories are directly involved in providing health services through government authorities, whereas the Commonwealth is predominantly involved in funding health services, many of which are privately provided, albeit usually in a highly (Commonwealth) regulated market.

Some of the largest expenditures by government on health services are direct Commonwealth payments to citizens and permanent residents to offset most of the fee per item cost of privately-provided services. Medical and pharmaceutical benefits together represent a little over 30 per cent of all governments' expenditure on health.[13] These are statutory entitlements to fixed reimbursements. These Commonwealth-funded health services are financed by way of standing 'special appropriations' – that is, the law which defines the program also provides for the continuous provision of funds from consolidated revenue to fund payments required by the program. In quasi-lay terms, Commonwealth funding is 'uncapped' or open-ended.

In contrast, most state and territory health services are funded by fixed annual grants paid to health services such as public hospitals. To support this, state and territory parliaments make annual appropriations of fixed amounts to fund their health services.

So, both the way in which governments fund, and the relationship they have with health services, are quite different between the Commonwealth and the states and territories.

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[12] M Foley (2008), A mixed public-private system for 2020, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[13] Australian Institute of Health and Welfare (2008), Health expenditure Australia 2006–07 (Australian Institute of Health and Welfare: Canberra).

In addition to these differences, one of the critically important consequences of the current separation of responsibilities for health between governments is a separation of expertise and perspective.

To put it bluntly, no level of government has a detailed understanding of all aspects of the health sector

To put it bluntly, no level of government has a detailed understanding of all aspects of the health sector.

Each level of government formulates policies in relation to its responsibilities that do not take account of the health system as a whole, or are designed to shift costs onto the other. It seems unlikely that anyone would support an approach to economic policy under which the Federal Treasury did not have a detailed understanding of major aspects of the economy, yet such a situation is the norm in health.

12.2.2 The Commonwealth and states and territories have fundamentally different capacities to fund health services

In 1942, the states and territories lost their ability to raise income tax to the Commonwealth, in support of the war effort. Since that time, all states and territories have been dependent on grants from the Commonwealth to meet their expenditure commitments, to a greater or lesser extent:

> *… the states rely on Commonwealth financial assistance to meet about 40 per cent of their average funding requirement*[14]

This is known as the 'vertical fiscal imbalance', or VFI. Vertical fiscal imbalance is a feature of many federations, but:

> *Australia has the greatest degree of vertical fiscal imbalance of any federal country*[15]

including the US and Canada.

Vertical fiscal imbalance is a crucial driver of the 'blame game' in health. States and territories have service obligations which they cannot meet from their own resources, and for which they must rely on Commonwealth grants. Any failure to meet public expectations in relation to state and territory provision of health services inevitably leads to claims and counter-claims about the adequacy of Commonwealth funding to do so.

This is not the whole cause of the blame game, but it is central to it.

12.2.3 Consequences for governance and funding of health services

These differences in the nature of government involvement in health care between levels of government in the Australian federation must be central to any discussion of proposed changes to the roles of governments in health.

For example, proposals to increase state exposure to significant additional areas of health spending, even if underwritten by Commonwealth grants, are unlikely to prove acceptable to states and territories.

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[14] Commonwealth Budget Paper No. 3: Australia's Federal Relations 2008–09 – Part 1: Overview of Australia's Federal Relations, at: http://www.ato.gov.au/budget/2008-09/content/bp3/html/bp3_overview-01.htm

[15] Public Finance and Vertical Fiscal Imbalance, Research Note No. 13 2002–03, Australian Parliamentary Library, at: http://www.aph.gov.au/library/Pubs/RN/2002-03/03rn13.htm

States and territories struggle to manage hospital outlays, even with a system of fixed annual budgets for which they can hold hospital boards and/or managers responsible. States are unlikely to be willing to increase the scope of health services for which they are accountable to the public where their capacity to meet those increased obligations is further dependent on Commonwealth grants.

In addition, in relation to any potential transfer of responsibility for Commonwealth benefit programs to states and territories, the states and territories have little experience in the management of such entitlement-based payments to individuals. They would be very unlikely to accept responsibility for open ended outlays on such programs unless they had very wide discretion to revise program arrangements so as to contain those outlays.

This could lead to a situation where, for example, different pharmaceuticals were subsidised to differing extents in different states, as states exercised their discretion and arrived at different decisions. This could also lead, in turn, to people crossing borders to get treatments or levels of subsidy available in one state or territory but not another. It seems unlikely that such an approach would be more efficient to administer, or have the same capacity, for example, to evaluate and regulate pharmaceuticals, as does the current national approach through the Pharmaceutical Benefits Scheme.

These factors suggest that it would be difficult to increase state government responsibilities for health services without fundamentally altering the revenue base they have to meet such additional responsibilities.

12.2.4 Aligning power with responsibility, and responsibility with capacity to pay

We would suggest that a basic tenet of good governance is that power and responsibility should be aligned. That is, as far as possible, a government should be directly responsible and accountable for the effects on services of its funding decisions. And, conversely, the fiscal implications of policies and program management decisions should rest with the government making the decisions.

In a general sense, then, a government that alters its level of funding for particular health services should be clearly and directly accountable for the consequences of that in terms of people's access to those services.

We would further suggest that the division of spending obligations between governments should be commensurate with their capacity to pay. Absent any major realignment of revenue raising capacity, this means that any proposed realignment between governments of health service and spending responsibilities should see greater direct involvement of the Commonwealth.

- Any proposed realignment between governments of health service and spending responsibilities should see greater direct involvement of the Commonwealth

It is reasonable to suggest that the 'blame game' in Australian federal relations is significantly a product of lack of adherence to these principles. The blame game in relation to public hospitals is arguably a conscious, sustained and, to a degree, successful attempt by states and territories to increase the Commonwealth's accountability in the eyes of the public for the limitations of public hospital services. States regard this as valid as they maintain that key aspects of Commonwealth policies, ranging from the adequacy of Commonwealth grants to states and territories, to the availability of residential aged care and access to primary medical care outside hospital emergency departments, are crucial in limiting public hospital performance.

12.3 Functions requiring national leadership

We indicated earlier in Section 12.1 that our consultations across Australia had uncovered a strong interest in 'national leadership' as a core element of the 'one health system' model.

We believe that there is considerable merit in identifying functions that would benefit from being undertaken on a national basis. We have used the word 'national' rather than 'Commonwealth' intentionally. By using this language, we are seeking to indicate the importance of some roles and functions occurring on a consistent national basis. This may well involve collaborative partnership arrangements between the Commonwealth and states and territories, as well as other bodies. National leadership does not necessarily translate to direct Commonwealth control.

We need one health system, not a public health system and a private health system, where 'ne'er the twain shall meet' ■

We also want to indicate strongly that national leadership must involve the effective participation of the whole health sector: public and private health services, and public and private funders of health care. National leadership should not, for example, be about national leadership on the quality of public hospital services only, with no regard to private hospital services. We need one health system, not a public health system and a private health system, where 'ne'er the twain shall meet'.

This framing of the issue – what roles and functions would benefit from national leadership – establishes a different mindset than only discussing whether the Commonwealth or states and territories should 'run' health.

To get the ball rolling on this debate, we have identified the following preliminary set of functions or responsibilities that we are proposing would benefit from national leadership. Importantly, we have cast this primarily as a list of functions or responsibilities. It is not a list of proposed new national agencies. Some of these functions could well be performed by changing or adding to the roles of existing agencies. We would welcome feedback on this listing, and on any other responsibilities that might be added to this listing.

National leadership on safety and quality of health care

Building on the existing responsibilities of the Australian Commission for Safety and Quality in Health Care (which currently is time limited and not incorporated), we see the need to consolidate and align a range of functions that support health professionals in working towards a high quality and safe health system. We also see the need to consolidate and align various service accreditation requirements. Chapter 15 outlines our proposals on safety and quality in more detail, but they include the establishment of a permanent, independent national body to provide leadership on safety and quality, including the development of performance indicators and national patient experience surveys and patient-reported outcome measures.

Health professional registration based on competencies

We support the move to national registration of health professions. This was one of the issues that health professionals raised with us as a major frustration during our consultations:

> *So I'm a Director of Nursing and if I could summarise one thing you could do is get rid of the requirements for multiple registrations, multiple checks and multiple accreditations. In my present role I have four registrations in different states, five accreditation systems applicable and four different police checks. A lot of them are obviously redundant!*[16]

As proposed in Chapter 14, we further believe there is a need to move to a system based upon recognition of competencies, rather than simply registration of health professions.

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[16] Director of Nursing (17 June 2008), National Health and Hospitals Reform Commission consultation meeting with health professionals in Cairns.

National Clinical Education and Training Agency

As also discussed in Chapter 14, perhaps the biggest single challenge Australia faces for the future of our health system is ensuring we have enough skilled health professionals. To meet this challenge, we believe a single body needs to be given the authority and responsibility to recommend the numbers of course places to be made available, and to fund the requisite clinical placements with the health sector across all health professions. Chapter 14 identifies the other important functions which we believe would benefit from a national approach under this agency.

National Health Promotion and Prevention Agency

As set out in Chapter 1, we propose the establishment of an independent national health promotion and prevention agency to bring a greater focus to prevention in our health system. Importantly, this agency would have carriage of the proposed Healthy Australia 2020 Goals. It would also be responsible for 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 system.

We have further proposed that this agency would collate and disseminate information about the efficacy and cost-effectiveness of health promotion and prevention interventions.

National health intervention assessment

Australians already benefit from a robust, national approach to decision-making involving the evaluation and funding of pharmaceuticals and medical services. In particular, Australia is regarded as a world leader in terms of its use of cost-effectiveness analysis in reaching decisions about the public funding and listing of pharmaceuticals on the Pharmaceutical Benefits Scheme.

- Australians already benefit from a robust, national approach to decision-making involving the evaluation and funding of pharmaceuticals and medical services

However, we are also aware that these two national processes sit side by side with a patchwork of other processes for evaluation of new technology, medical devices and prostheses. Some states have established their own technology assessment processes which do not necessarily use the same criteria as the existing national approaches. In addition, there may be only limited channels to assess the evidence on other 'interventions' including allied health services, complementary medicine, or health promotion and prevention activities. We are also aware from our submissions and our consultation meetings that there is considerable duplication across states, across private health insurers, and across individual health services in how they assess and make decisions on which health interventions are beneficial. There is also support for national leadership on this issue. For example:

> *ACT Health recommends that the National Health and Hospitals Reform Commission acknowledge that health technology is a major driver of costs and investigate mechanisms to provide a sustainable funding process. ACT Health would support the development of a sensible model to assess which technologies to adopt, similar to the processes used for assessing new pharmaceuticals.*[17]
>
> *We have an enviable system of establishing the value of modern medicines in the PBS price negotiations, some medical technologies are reviewed through the Medical Services Advisory Committee (MSAC), and many more are assessed by joint committees of insurers and manufacturers in a tortuous process that sometimes overlaps with MSAC reviews. Most medical interventions are not subject to stringent evaluation. Most Australians do not know the costs, risks and benefits of the care they consume, and they are facing inexplicable co-payments with modern drugs and medical devices. These gaps in transparency might be filled in part by a national process of technology assessment similar to the process followed by the UK National Institute for Clinical Excellence (NICE), recognising that modern drugs and medical devices are very different in their evidence requirements.*[18]

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[17] ACT Health (2008), Submission 5 to the National Health and Hospitals Reform Commission.

[18] P Gross (2008), Submission 448 to the National Health and Hospitals Reform Commission.

What we are foreshadowing here is our support for the concept of an 'umbrella' approach to the consistent national evaluation of a broad range of health interventions

- This is a huge and complex issue, and we cannot fully do justice to this issue within our Interim Report. What we are foreshadowing here is our support for the concept of an 'umbrella' approach to the consistent national evaluation of a broad range of health interventions. This does not necessarily imply that the identical approach (or how evidence is used and collected) to decision-making on pharmaceuticals has to be rigidly applied to other health interventions. What it does mean is that we need to move towards more common processes. So, for example, a common approach might be applied to evaluating a range of interventions for their effectiveness in managing obesity (such as a new anti-obesity drug and a new gastric banding procedure), rather than evaluating them separately. It might also facilitate evaluation of new interventions that involve close linkage of diagnosis and treatment (such as personalised medicines, responding to the new genomics – especially in the diagnosis and treatment of cancer – and genetic testing and treatment).

Using the distinction made by Harris and Mortimer in one of our commissioned discussion papers[19], it may be that a consistent national approach could also be used to evaluate 'clinical prevention' activities (involving interactions between health professionals and individual patients) and medical and pharmaceutical interventions. Continuing our example above, this might mean that we evaluate the value of exercise programs designed by an exercise physiologist in managing obesity in parallel with medical and pharmaceutical interventions. (Our preliminary position is that broader health promotion and prevention initiatives – such as social marketing campaigns – would probably benefit from a separate approach, under the guidance of the proposed national health promotion and prevention agency.)

National regulation of private hospitals

We also heard about the need to reform private hospital regulation.

> *The starting point for reform is to rationalise the existing plethora of regulation and reporting requirements imposed on private hospitals. The National Health and Hospitals Reform Commission should establish what information and data is important for private hospitals to report, and require that this information and data be reported once, nationally.*[20]

The Commonwealth Government has a key role in relation to privately-funded hospital services through its responsibility for policy, funding and regulation of private health insurance, as well as its responsibility for medical and pharmaceutical benefits for private patients in hospitals. Over the last couple of decades, private hospitals have been consolidated and are now increasingly owned by chains operating in multiple states. Different regulatory regimes for private hospitals in different states contribute to an oversight burden. National regulation of private hospitals would ensure national consistency and simplify compliance for national private hospital operators and those with hospitals in more than one state.

National support for innovation

Currently, health service innovations are often poorly known beyond the health service in which they were developed, let alone able to be recognised and adopted in other health services across the country. In an environment of tightly constrained resources, the pressures to maximise those devoted to treatment can mean that there is scant investment in fostering, rewarding and disseminating service innovations:

> *There is a lack of evaluation and cumulative learning in the Australian health care system. A mass of experimentation is conducted at the local level, through, for example, Divisions of General Practice and Area Health Services, but information on successful innovations is spread haphazardly, with no systematic evaluation. National leadership is needed to transform local successes into initiatives that operate across the health system.*[21]

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[19] A Harris and D Mortimer (2008), A preventative priorities advisory committee and prevention benefits schedule for Australia, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

[20] Australian Private Hospitals Association (2008), Submission 10 to National Health and Hospitals Reform Commission.

[21] Menzies Centre for Health Policy (2008), Submission 420 to the National Health and Hospitals Reform Commission.

In Chapter 15, we propose several mechanisms to enhance the national uptake of innovation across public and private health services. This includes an expanded role for the National Institute of Clinical Studies in undertaking a 'clearinghouse' function and the adoption of a range of initiatives to foster the sharing of best practice.

National performance reporting and accountability framework

There is a clear need for improved, public availability of nationally consistent information on comparative health service performance. As we heard:

> *My first proposal is that a national report of performance reporting should be available at hospital level, rather than only at aggregated state level … This would place all Australian hospitals in a national context and provide comparisons for them across Australia.*
>
> - *Hospitals like to strive to be the best and the national context offers a greater challenge. …*
> - *It means we start thinking nationally, as a national health care system with consistent performance and striving for excellence, rather than always at state level.*[22]

- There is a clear need for improved, public availability of nationally consistent information on comparative health service performance

Development and implementation of nationally consistent information on comparative health system performance will reduce duplication and overlap, improve consistency, lower compliance costs for organisations that operate services nationally, and enable faster development.

National Aboriginal and Torres Strait Islander Health Authority

As discussed in Chapter 8, improving health and access to health services for Aboriginal and Torres Strait Islander peoples must be given the highest priority. To lead the additional investment we believe is required, we suggest strengthening the purchasing role through the establishment of a National Aboriginal and Torres Strait Islander Health Authority. The Authority would have clear authority and responsibility for purchasing 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 and to ensure high quality and timely access.

Reform direction 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.

In conclusion, we want to stress that our proposal for national leadership on some important roles and responsibilities stands independently. We are proposing that this can occur irrespective of other major changes to the governance of health services discussed in Section 12.5.

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[22] M Draper (2008), Submission 265 to the National Health and Hospitals Reform Commission.

12.4 Approaches to building local flexibility and public voice

We turn now to the second core issue of local flexibility and local input into decision-making about health services. Again, the approaches we outline below should be considered as integral to driving quality performance across the whole Australian health system. They are not an optional extra. We are proposing that they can, and should, occur irrespective of whether there are other changes to governance arrangements between Commonwealth, state and territory governments.

It was evident that many people wanted 'the best of both worlds'

In our consultations, it was evident that many people wanted 'the best of both worlds'. They wanted national leadership shaping 'one health system' – a well-funded system with the same national entitlements and good access and quality outcomes for everyone – but they also wanted 'local flexibility'.

Like the concept of 'one health system', the concept of 'local flexibility' can have many different interpretations. At one extreme, it might mean 'send a blank cheque' and let us decide what health services we need for our community and how best to organise them. But the term was also used by many people to describe their interest in improvements in participatory and consultative structures at regional and local levels. Local flexibility can have many 'shades of grey', depending upon how much the emphasis is on decision-making, consultation, funding or purchasing of health services.

We wanted to take this opportunity to link the concept of 'local flexibility' back to our principle of 'public voice and community engagement' (see Figure 12.2).

Figure 12.2: Our principle on 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.

There is clearly overlap between these concepts, although they each add value in their own right. One way of thinking about them is that 'local flexibility' is what is needed for health services to be able to take note of community or collective input into decision-making (and other local processes), while public voice and community engagement has more of an emphasis on the perspectives of individuals and families about their health services and priorities. Moreover, local flexibility is often about flexibility from the perspective of health services. For example, can funding be used to provide services outside those specified in health service 'program' arrangements? What accountability and reporting requirements are health services required to undertake? Are there regional or local structures to encourage joint action on population health and integrated planning across health services? The mirror image of this is how people and their families contribute to shaping their health services.

Recognising that local flexibility and public voice are related, but separate, concepts, we want to highlight briefly some approaches in both these areas that may be relevant to strengthening governance at the local level.

12.4.1 Strengthening local flexibility

This interim report canvasses a number of strategies to strengthen local flexibility.

In Chapter 2, we have proposed that service coordination and population health planning priorities could be enhanced at the local level through the establishment of Divisions of Primary Health Care. We see these regional structures as providing one mechanism to 'join up' and strengthen the platform of primary health care services at a local level. We have outlined that these Divisions of Primary Health Care could develop 'wellness and prevention' profiles for their communities. They could also identify current strengths and gaps within service provision. Local flexibility could be enhanced as Divisions of Primary Health Care provide a counter-balance to the views of national and state governments about what is important and how services can best be designed to meet the needs of their local communities.

- We see these regional structures as providing one mechanism to 'join up' and strengthen the platform of primary health care services at a local level

These approaches are further picked up in our discussion in Chapter 1 where we propose that local communities and health services may want to play a leading role in action towards the achievement of the proposed Healthy Australia 2020 Goals. We have suggested 'local flexibility' as we anticipate that local communities and health services may want to focus on particular goals that resonate with the health priorities identified by their community.

In Chapter 9, we have identified several approaches to encouraging locally designed and flexible models of care in remote and small rural communities. We have proposed that more equitable and flexible funding could be provided through funding remote and small rural communities at the national average of medical benefits and primary health care service funding. This means that, even though such communities may not otherwise access Medicare Benefits Schedule funding, they would be able to have access to equivalent funding dollars. This would allow them to provide primary health care services in a way that meets their needs, recognising the workforce challenges in these communities. We have also proposed the expansion of the concept of the 'multi-purpose service' model to towns with catchment populations of approximately 12,000. Once again, this approach provides the capacity to adapt to local circumstances, providing funds flexibly across health and aged care programs according to community needs.

12.4.2 Strengthening public voice

Community participation is a very broad concept and captures a wide range of possible strategies, many of which are important to improving governance at the local and regional level. One useful definition is that:

> *Participation occurs when consumers, carers and community members are meaningfully involved in decision making about health policy and planning, care and treatment, and the wellbeing of themselves and the community. It is about having your say, thinking about why you believe in your views, and listening to the views and ideas of others. In working together, decisions may include a range of perspectives.*[23]

The strategies that can be used to give effect to participation range from the passive provision of information, to active consultation with community groups, to involving consumers and the community as partners in decision-making through either formal or informal mechanisms.

One of our submissions provided a useful framework to develop our public voice principle. Sophie Hill and Mary Draper[24] proposed that public voice and consumer participation could be strengthened across four separate dimensions as follows:

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[23] Victorian Department of Human Services (2006), Doing it with us not for us: Participation in your health service system, 2006–2009, at: http://www.health.vic.gov.au/consumer/downloads/do_it_with_us.pdf

[24] S Hill and M Draper (2008), Submission 403 to the National Health and Hospitals Reform Commission.

- Democratic participation – this is based on individual and collective participation in decision making. Strategies include: consultation; involvement in decisions; the use of personal health records; representation; consumer membership on decision-making structures; consumer advisory structures; and accountability to consumers.
- Legal approaches – this is based on defined rights and access to judicial processes. Strategies include: health charters; the right to complain; legal redress; legislation; transparent decision-making; and advocacy.
- Market solutions – this is based on market information to create more responsive services. Strategies include: providing information on health services; marketing; statements of expectations; and consumer surveys.
- Scientific approaches – this is based on the use of statistics and evidence. Strategies include: evidence-based medicine; outcomes data; clinical practice guidelines; patient surveys; and research into the patient experience.

We believe that this provides a useful framework and a broad checklist of strategies to foster a stronger public voice in the health system.

Many of the elements in this public voice framework have been canvassed elsewhere in our report. We have proposed in Chapter 4 that there should be public reporting by public and private hospitals on indicators of access, efficiency and quality of care provided. In Chapter 15, we take this one step further in proposing that all hospitals, residential aged care services and Comprehensive Primary Health Care Centres report annually on their quality improvement and research activities, including reporting on actions arising from investigation of adverse events. We have also proposed in Chapter 15 that an independent national quality and safety organisation should take the lead in the development of a national patient experience questionnaire and patient-reported outcome measures.

In conclusion, we would welcome further feedback on approaches to strengthen local flexibility and public voice in the health system.

12.5 Options for better governance

As outlined in Section 12.1, there was a diversity of views from the submissions and consultations about the appropriate roles of Commonwealth, state and territory governments. However, many of the submissions expressed a simple view (for example, that the Commonwealth should take over responsibility), but lacked detail as to how the preferred change might work out on the ground.

The 'devil is in the detail' with proposals to reform the governance of the health system

■ The 'devil is in the detail' with proposals to reform the governance of the health system. Accordingly, we now outline the detail of three major possible approaches to improving governance of the Australian health system. The three models are:

- Option A – continued shared responsibility between governments, with clearer accountability and greater Commonwealth responsibility for some functions.
- Option B – Commonwealth to have sole responsibility for all aspects of health care, with delivery through regional health authorities.
- Option C – Commonwealth to have sole responsibility for all aspects of health care, with establishment of compulsory social insurance to fund local delivery of health services.

In Chapter 2, we indicated our strong support for the Commonwealth to take greater responsibility for all primary health care services. We want to make it clear that we believe this should occur, no matter what other changes occur to the governance of the health system.

Reform direction 12.2

We propose that the Commonwealth should take responsibility for policy and funding of all primary health care.

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

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

- becoming responsible for all funding, policy and regulation for primary health care and community health services, including those currently funded by states as already outlined in Chapter 2;
- paying to states and territories a substantial hospital benefit per episode of the efficient costs of inpatient treatment and of emergency department treatment (set at, say, 40 per cent); and
- paying, using a casemix classification, 100 per cent of the efficient costs of delivery of hospital outpatient treatments.

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

Option A – key features

Both levels of government would remain involved in funding and decision making about health services, and there would be shared planning of the whole health system, state by state.

An overarching National Health Strategy would be developed and agreed by the Commonwealth, and states and territories setting out the framework for joint funding and policy in relation to health and health care, including aged care.

■ An overarching National Health Strategy would be developed and agreed by the Commonwealth, and states and territories

Eight state and territory health strategies would be developed and agreed bilaterally between the Commonwealth and each state and territory, with national incentive payments tied to achieving key initiatives within each state or territory strategy, in line with the national strategy.

It would be expected that key elements in the national (and each state and territory) plan would be the reforms proposed elsewhere in this report, including, for example:

- integrated primary health care catering for people with chronic and complex care needs, joining up Commonwealth-funded general practice and previously state-funded community health services (see Chapter 2);
- a single national system of regulation (of professions, of services, and of public health) (see Chapters 1 and 14, and Section 12.3);
- a national initiative to encompass oral health (see Chapter 11);
- improved provision of mental health services (see Chapter 10);
- a nationally consistent approach to activity-based funding of public hospitals for admitted and non admitted services to improve efficiency and access (see Chapter 4);
- a clear focus and funding for improved Indigenous health (see Chapter 8); and
- national audit and evaluation and reporting of policy and service delivery against agreed benchmarks (see Section 12.3).

In particular, it is proposed under this option that the Commonwealth would pay per patient episode, a proportion – say, 40 per cent – of the efficient cost of delivery of admitted patient care in hospital and of care in a hospital emergency department. Episodes of care would be classified and paid for using casemix classifications such as Australian Refined – Diagnosis Related Groups (AR-DRGs) for admitted acute care episodes, the Casemix Rehabilitation and Funding Tree (CRAFT) or Sub-acute, Non-acute and Palliative care (SNAP) classifications for sub-acute care and rehabilitation, and an appropriate casemix classification for emergency department episodes.

The total volume of services funded by the Commonwealth in this way would be open ended, as it is with medical and pharmaceutical benefits. The limit on total outlays would be the level of expenditure each state or territory would support to pay for the balance of the cost of hospital treatment. In this way, the Commonwealth contribution for public hospitals would be transparent while accountability for the total volume of services would rest unequivocally with states and territories. States would continue to bear the cost of any inefficiency in delivery, and of meeting the majority of the cost of admitted patient care, thus ensuring rigorous review of additional services as part of state and territory budget processes.

The Commonwealth would also fund 100 per cent of the costs of non-admitted hospital outpatient treatment (other than emergency department care) using a casemix classification such as the Victorian Ambulatory Care System (VACS). The volume of these payments would not be open ended. Instead, the Commonwealth would negotiate activity-based budgets for hospital outpatients with each state and territory under the bilateral agreements.

Option A – discussion

Continuing to have both levels of government involved ensures that the existing advantages of the accountability of states and territories to their own populations are retained, and that the potential diversity and innovation that comes with state involvement continues.

This approach also directly strengthens the provision of integrated care by making funding and policy for all non admitted care – apart from emergency department care but including hospital outpatient care, primary health care and community health services – the responsibility of the Commonwealth. It also creates incentives for the Commonwealth to shape these programs with regard to the impact on people's need for emergency department and admitted hospital care, as the Commonwealth will also be liable to make a payment for each and every episode of admitted and emergency department care:

- To the extent that people present to hospital for conditions that could have been prevented by greater investment in prevention and primary health care, the Commonwealth will have a direct incentive to address these.
- To the extent that older people remain in hospital awaiting aged care, again the Commonwealth will have a direct incentive to address this, as it will pay a significant proportion of the cost of caring for such people in hospital.

The Commonwealth payment will be based on the efficient cost of delivery as determined by costing of hospital episodes across all hospitals, public and private ■

The use of a partial, per case payment from the Commonwealth for each admitted patient episode will also serve to drive improved efficiency in the delivery of these most expensive health care services, as the Commonwealth payment will be based on the efficient cost of delivery as determined by costing of hospital episodes across all hospitals, public and private. Hospitals that can operate at or below the efficient cost will do relatively better than those that do not, unless states and territories choose to underwrite less efficient services through their component of the total funding.

A model of funding for public hospitals under which the Commonwealth pays a defined benefit for each hospital service, for admitted and non-admitted patients, could substantially defuse the blame game by making plain the basis of the Commonwealth contribution, and by the Commonwealth's approach not limiting the total treatments available: the level of services available to a state or territory population would be clearly seen to be the result of state or territory decisions.

The transfer of greater funding responsibility to the Commonwealth (and the associated adjustment of grants to states) also serves to reduce the vertical fiscal imbalance, with state responsibilities for health spending being more in line with their capacity to pay.

Both levels of government would be more directly exposed to hospital costs, and so would have a powerful shared interest in ensuring, as far as possible, that hospitals are used only for services that are best provided by hospitals.

The outcome of this should be greater cooperation between levels of government on initiatives such as hospital in the home, provision of step down and sub-acute care, provision of post-acute care, and effective linkage with primary health care.

This option means the states and territories would have significant and continuing responsibilities in the health sector, with a significant vested interest in prevention strategies to reduce potential demand for hospital care. This would thus ensure their continued interest in creating good links between the health sector and other sectors of their responsibility which impact on prevention (education, transport, urban planning).

Nevertheless, the continued involvement of two levels of government would still create some challenges for coordination of policies and programs. While the proposed approach substantially realigns and makes clearer the responsibilities of the two levels of government, there would be new boundaries across which there might still be some tension. For example, states and territories might maintain that levels of Commonwealth funding for outpatient treatments were insufficient, resulting in an increased need to admit patients for treatment, or that Commonwealth policies in primary health care were still not as effective as they should be in preventing avoidable hospitalisations. At least under this approach, the Commonwealth would have a direct share in the costs of hospitalisation and so would have a direct interest in understanding and addressing such issues.

Although this proposal involves a significant shift in responsibility to the Commonwealth, and requires development of a national payment system (at least for Commonwealth payments for hospital services), it involves less disruption to existing roles and responsibilities compared to the other options outlined here. The implementation and transition risks for this option are thus the least of our three options. Interestingly, for advocates of the other two options outlined below, adoption of Option A could be seen as a first or transitional step towards implementation of Option B or Option C.

- Adoption of Option A could be seen as a first or transitional step towards implementation of Option B or Option C

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

The second option we wish to canvass is a transfer of 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. As we heard:

> *A fundamental question is … whether the divided responsibilities between Commonwealth and states can serve a functionally effective and coordinated national system … it needs to be tested as to whether effective coordination will require over-riding Commonwealth authority.*[25]

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[25] Melbourne Monash Clinical Working Group (2008), Submission 112 to the National Health and Hospitals Reform Commission.

Option B – key features

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

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

Option B requires agreement to transfer substantial funding (almost $24 billion) from states and territories to the Commonwealth ■

Option B requires agreement to transfer substantial funding (almost $24 billion) from states and territories to the Commonwealth. In 2006–07, Option B would have entailed transferring from the states to the Commonwealth:

- the responsibility for administering annual recurrent expenditure of about $20.3 billion comprising:
  - $14.3 billion for public hospitals;
  - $3.6 billion for community health services and other non-institutional expenditure;
  - $1.2 billion for patient transport including ambulance services;
  - $0.7 billion for public health
  - $0.5 billion for public dental care; and
  - annual capital expenditure and capital depreciation of about $3.5 billion.

Existing institutional and legislative frameworks from each state and territory (for example, regulation of ambulance services) would be replaced by a national, Commonwealth institutional and legislative framework. So, instead of eight sets of legislative or organisational frameworks for health services, there would be single national legislation and a single national approach.

It is proposed under this option that the Commonwealth would establish regional statutory authorities with responsibility to plan and operate public health services for that population. That is, these authorities would take over most of the formerly state government funded health services within each region. Another approach would be for states to either establish these regional authorities themselves or, in fact, for states to become the regional authorities, but with policy and funding being a Commonwealth responsibility. (The latter situation might occur in a small state such as Tasmania). This is essentially the model for universities.

Under Option B, existing national payments (such as the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and aged care) would be retained. The major elements of the regional budget would also be determined on a national basis – for example, using a national approach to activity-based budgets for regional hospital services.

Population health initiatives requiring a state or national focus, such as tobacco regulation or social marketing campaigns, would be managed at the national level, although regions might be enlisted in aspects of national initiatives.

Education and training would be a national program, through the National Clinical Education and Training Agency as briefly outlined earlier in this chapter, with specific funding to regions based on training places provided and training outcomes achieved.

The focus of regional authorities would be on planning, commissioning and operating the integrated provision of health services for which they are responsible within their regions. This could involve linkage to private and not-for-profit providers of health and aged care services in that region. Regional performance in service delivery and minimum requirements such as service accreditation would be monitored nationally.

Regions would be required to develop three to five year regional plans, with clear involvement from health services and the region's community. These plans would identify local priorities for service development and health improvement. The Commonwealth would negotiate three-year funding agreements with each regional authority detailing the elements of proposed regional plans for funding.

New functions for the Commonwealth would probably include:

- determination and negotiation of annual budgets for regions covering public hospitals and other former state government funded health services within scope:
    - Commonwealth would move to national standard activity-based budgets for public hospital services; and
    - would be likely to adopt simpler funding agreement approaches for smaller services.
- a variety of arrangements might also be used to share financial risk with regions, including:
    - fixed or maximum total payments (that is, grants) to regions, with regions taking the risk that they will have to treat more people than anticipated; and
    - tapered payments, where the Commonwealth shares with regions the cost of additional services above a specified level by paying additional amounts for the additional services, but at a diminishing rate.
- the Commonwealth would also set rules around maximum user charges for types of services – these would presumably reflect, at least initially, current rules.
- planning for all services with community participation and with services and providers involved through the regional authorities and the Divisions of Primary Health Care.
- priority setting and funding for major capital works projects.
- performance monitoring across all health services, standardised nationally.
- quality standards and accreditation requirements, standardised nationally.

Industrial relations would likely be devolved, as is currently the case in areas of existing Commonwealth responsibility including aged care, Aboriginal and Torres Strait Islander health services, and services for veterans and their families.

This option does not, of itself, require changes to private health insurance or existing universal programs (medical and pharmaceutical benefits and hospital treatment as a public patient). However, the Commonwealth would be exposed to a different range of pressures that might shape its policies on these issues.

Option B – discussion

Option B would substantially resolve the blame game between governments in regard to health. It would make one government squarely accountable for all of health and health care. It is likely that there would continue to be some tension between regional health authorities and the Commonwealth around the adequacy of funding to support the regional health services, and possibly also around the boundaries between the continued national programs (Medicare Benefits Schedule and Pharmaceutical Benefits Scheme) and those funded through a regional budget.

■ Option B would substantially resolve the blame game between governments in regard to health

However, there would be no doubt as to which government was responsible for the health system as a whole. The mechanisms we propose (especially the use of activity-based funding) should make the basis of funding clearer, and significantly reduce incentives for cost shifting between national programs and regionally-funded services.

We expect that the Commonwealth would move to resolve many of the inconsistencies and competing arrangements that are a feature of the current situation, leading to an improved capacity to integrate care around people's needs. For example, the provision of pharmaceuticals in and out of hospital could be sensibly aligned. Similarly, there would be strong incentives on the Commonwealth for primary medical care in hospital emergency departments and in the community to be better aligned, and former state government funded and run community health services could work directly with private GPs.

The Commonwealth would have to acquire expertise in all aspects of the health sector to underpin its broader role, which in itself should enable better national policy development across all aspects of health and health care.

The establishment of regional health authorities would also facilitate more coordinated delivery of care, fostering relationships not only between the services for which a regional authority is responsible, but also with other services, including privately-provided services within a region, including through the Divisions of Primary Health Care. The regional health authorities should also, through community representation, provide a mechanism for people to have a greater say in the governance of their local health services.

We believe this option could be an improvement on current arrangements in terms of ensuring a rational allocation of funds across the various programs. It would contain little or no incentive to cost shift and ensure a greater focus across the system on effectiveness of care and innovation, with some flexibility in the use of funding by regional health authorities.

However, Option B requires a major shift of funds and management expertise from the states to the Commonwealth, with all the attendant risks of major change. There is a risk of loss of the diversity and local innovation and adaptation that are a feature of state involvement in health care presently. However, new regional health authorities could have the potential to foster local innovation.

This option potentially weakens community and electoral accountability and responsiveness by having only the national level of government involved in health and health care. Arguably, state and territory governments are more responsive to the views of their electorate than a national government that has to balance the interests of Perth or Launceston against those of Sydney or the Gold Coast. It also separates health from other state government managed programs such as housing, community services and education, with a consequent loss of opportunity to integrate health care with those programs, and a reduced incentive for states to shape those programs to contribute to improved health outcomes.

There is also a risk in having a single regional body for each region that it will be vulnerable to 'provider capture' and/or that its role as a major supplier of many health services will lead it to be unresponsive. This may need to be addressed by creating institutional arrangements at the regional level that ensure a strong public voice, with separate articulation of interests as between the regional body and the community (for example, through the creation of a separate regional community health council) to ensure there is clear accountability to the local community.

Alternatively, there could be strong, direct representation of the community on the regional body, possibly through inclusion of one or more members appointed by the elected local government or appointing suitably qualified member(s) of the community. Consistent with the principles of good governance in a professional board, either of the above membership options, though, would require the board members to act in the interests of the regional health authority, not their own constituencies.

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

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

Option C – key features

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

■ Social insuranceis one of the earliest forms of universal health cover still used in many Western European countries

This approach of tax-funded cover through competing health plans is generally termed 'social insurance' to distinguish it from private health insurance (where people pay directly out of their own pockets to buy insurance) and public insurance (where governments use taxes to meet most of the costs of health services directly). Social insurance is one of the earliest forms of universal health cover still used in many Western European countries.[26]

Under this approach, the Commonwealth would establish a national regulatory framework for the operation of the health plans. This might include:

- prudential requirements;
- scope of health services to be covered (and possibly defined benefits and methods of payment such as use of a common schedule of items for medical services, use of Diagnosis Related Groups for payment for admitted patient services); and
- provision of subsidies only for pharmaceuticals evaluated as relatively cost effective by the Pharmaceutical Benefits Advisory Committee.

Aspects of the regulatory regime (for example, prudential requirements) would be similar to those for current private health insurance, but with health plans having responsibility for all health cover for their enrolled members.

People would be entitled to enrol with their health plan of choice, and every Australian citizen and permanent resident would be required to be enrolled with a health plan. In this regard, social insurance for health care would be similar to compulsory superannuation with fund of choice.

Health plans would have no right of refusal – that is, no right to refuse to have an individual as a member of their plan. They would be required to offer cover to rural, regional and remote people on the same basis as to those living in cities.

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[26] M Foley (2008), A mixed public-private system for 2020, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

The Commonwealth Government would raise funding through taxation[27], via an identified, transparent health levy to meet the full costs of the social insurance scheme. This funding would be allocated to a health plan of the citizen's choice by the Commonwealth Government based on the 'risk adjusted' membership profile of each plan. Risk adjustment would be done actuarially, to reflect the expected relative spending on people by characteristics not under the control of the plans. Hence, the share of the total tax pool allocated to a health plan would be adjusted prospectively to reflect the relative cost of all people's past use of health services adjusted for age, sex, location and health status (including existing conditions), and any other factors found to be relevant.

Had such a scheme operated in Australia in 2006–07, to cover 69 per cent of health care expenditure (as did governments in that year under current arrangements), the average, annual payment per capita to a health plan would have been around $3250. This would have ranged from a low of perhaps a hundred dollars or less for some people, to many tens of thousands of dollars for other people, based on their characteristics as taken into account in the risk adjustment model used. All government expenditure on health and health care in 2006–07 equated to about 14 per cent of taxable income. So, the levy to fund the scheme fully to provide the same coverage as under current arrangements would also be around 14 per cent of taxable income. This is not an additional tax – rather, it is just identifying the component of taxation that already goes to health and health care. Actual total taxation including the levy would be no higher, provided the total funding under the scheme is the same as is met by governments currently.

Under Option C, health plans would be required by regulation to cover essentially all of the same services covered under existing universal and state government schemes. However, they would be free to strike their own arrangements with providers, including entering into preferred provider arrangements. Co-payments for mandatory coverage could be limited by regulation.

Health plans and/or third party insurers would be permitted to offer separate additional tables of cover for an additional premium, but would not be able to use such additional premium revenue to top up the government allocation for mandatory service delivery.[28]

Large health service provider organisations, or networks of providers, may be permitted to offer health plans, provided they meet the same requirements as all other health plans.

As with Option B, population health initiatives requiring a state or national focus (such as tobacco regulation or social marketing campaigns) would probably continue to be managed by governments at the national and state level. However, health plans might be enlisted in promoting aspects of national initiatives to their members. Education and training of health professionals would also be a national program, with specific funding to health services (independent of health plans) for training provided and training outcomes achieved.

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[27] Two long-standing social insurance regimes, in France and Germany, raise a large proportion of their revenue through employee and employer contributions. In both cases these contributions are supplemented by public funding from taxation. In effect the employment contributions are a tax, and arguably raising the funds through tax is more efficient. In addition, if funds are raised through tax, then the government can ensure that the distribution of funds to health plans is directly risk-adjusted, rather than relying on reinsurance arrangements to equalise membership risk between plans at the margin. Also raising funds through taxation simplifies providing contributions for those not in work, including retirees. That said, in a scheme very recently introduced in the Netherlands, half the funding is raised through tax and half the funding for adults is raised from direct premiums according to the health plan they choose. This is seen as providing people with a clearer understanding of the costs of their choices. However, it requires a complementary tax rebate to offset the differences in people's capacity to pay. The Netherlands scheme also involves a high degree of reinsurance (risk adjustment based on actual claims experience, after the event) which can undermine incentives for health plans to be efficient purchasers of the most effective services. For further information on the Netherlands approach, see J Stoelwinder (2008), Medicare Choice? Insights from the Netherlands health insurance reforms (Australian Centre for Health Research), at: http://www.achr.com.au/pdfs/MedicareChoice.pdf.

[28] It is worth noting that in both the French and German schemes, social insurance does not cover the full cost of health care. People are permitted to take out additional cover, privately funded, to pay the gap. Poorer people are provided with such additional cover funded by the government from taxation. While such cover ensures no cost barriers to people's access, it increases the likelihood that people will make greater use of at least some forms of health care, and that providers will feel less constrained in increasing their charges. In 2005, using OECD data, health care represented 11.1 per cent of France's GDP, 10.7 per cent of Germany's GDP but only 8.8 per cent of Australia's GDP (Australian Institute of Health and Welfare 2008, Australia's health 2008, Australian Institute of Health and Welfare: Canberra). Conversely, expenditure on out-of-pocket costs as a share of GDP in 2005 was 1.4 per cent in France, 2.4 per cent in Germany and 2.8 per cent in Australia (Australian Institute of Health and Welfare 2008, Australia's health 2008, Australian Institute of Health and Welfare: Canberra).

Social insurance separates governments from direct payments to, or funding of, health services for health care. In general, European social insurance has also operated as indemnity insurance, similar to the medical and pharmaceutical benefits schemes in Australia. That is, health services charge people, who are then reimbursed for around 70 per cent of the costs by their health plan. This means that even publicly owned and operated health services operate more like private health services, raising revenue through charges, and being paid according to the work they do (i.e. activity-based payment), rather than operating on fixed budgets. Reputedly, and not surprisingly, waiting lists for hospital services, for example, are not an issue in the way that they are (or have been) in budget-funded systems such as the UK and Australian public hospitals.

- Social insurance separates governments from direct payments to, or funding of, health services for health care

Option C – discussion

Key strengths of social insurance are the incentives for health plans to be responsive to the needs of their members and to purchase services in an integrated way to meet those needs. Accountability is strengthened by people's capacity to change to another health plan if they are unsatisfied with the one with which they are currently enrolled.

This approach also provides competitive pressures for efficiency, with health plans having an incentive to maximise the cover they can offer to attract more members while maintaining or improving their operating margins.

The competitive pressures in this approach could also drive innovation in funding and purchasing of services, and in health services seeking to attract members of health plans to use their services and so maximise their revenue. Health plans also have an incentive to take initiatives that will improve the health of their members to lower their expenditure on health care and to purchase health services with a focus on high quality performance and outcomes.

The use of taxes to fund health plans ensures that contributions are equitable with the better off contributing more. Moreover, the transfers from tax to the health plans are based on the person's relative needs, independent of the level of tax they pay.

Potential downsides with social insurance include transaction costs. Relative to Option B, the social insurance option would involve health services having to negotiate arrangements with many different health plans. There may also be additional complexity for consumers trying to establish which health plan will best meet their needs. Again, relative to Option B, it would be expected that a greater share of total spending would go on marketing as health plans would compete for members though advertising, sponsorships and similar activities. There would be potential loss of economies of scale currently achieved in the administration of the major national programs.

This option also requires the greatest departure from existing approaches, with all the attendant risks inherent in such a fundamental change.

Careful consideration is also required as to how social insurance would fit with private insurance. It is suggested that private health insurance would continue to have a similar role as it does in the current system – providing cover for services not included in social insurance and for levels of amenity not covered by social insurance.

Reform direction 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.

Concluding comments

We welcome feedback on each of these three options to improve the governance of Australian health services.

13. Raising and spending money for health services

Key messages

- Australia now spends $94 billion or about 9.0 per cent of gross domestic product on health services. This level of spending is about what would be expected given the size of our economy relative to other countries.
- Investment in the capital infrastructure of our health services accounts for about $5.3 billion of the $94 billion, or 5.6 per cent of total health spending. Historically, most capital spending has been directed towards acute hospitals, with relatively low capital investment in other health services, including community-based services and sub-acute services.
- Health and aged care spending is projected to increase to $246 billion or 12.4 per cent of gross domestic product by 2032–33. Caring for people with chronic diseases will represent one of the major reasons for this growth, with spending on diabetes and dementia among the fastest growing areas.
- The Australian health system benefits from access to a mix of both public and private financing streams. Many other countries are seeking to achieve a balance of public and private financing and the Australian model should be preserved.
- We currently lack good mechanisms to get community feedback on how much we should spend on health services, whether particular services should be funded publicly or privately and other aspects of priority setting in health care.
- An increased share of health costs are now being met directly by Australian households, rather than through taxation or private health insurance. In 2003–04, Australian households spent, on average, about 5.3 per cent of their weekly budget on paying for health services.
- People may incur very high costs for some health services that sit outside our universal access programs (public hospitals, the MBS and PBS). Access to dental care and aids and appliances represents a significant cost burden for some households (with the risk of families not using necessary services). A better system of safety nets is needed to support equitable access to necessary health services. .
- We need to ensure that funding approaches achieve our objectives for health services that improve patient outcomes and are efficient, and that additional investment by government converts into real improvements in access and quality.

Our reform directions

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.
- 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.
- 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.

> *Don't tell me where your priorities are. Show me where you spend your money and I'll tell you what they are.*[1]

How and what we spend on health services sheds light on our real priorities ■

How and what we spend on health services sheds light on our real priorities. During our consultations with the community and health professionals, we frequently heard views about services on which governments should spend more money or how they should change the balance of their spending. Whether individuals and families were paying too much or too little was also the topic of sometimes vigorous debate.

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[1] J Frick (undated), at: http://thinkexist.com/quotes/with/keyword/priorities

Financing and funding of the health system can be imagined as part of a circular process. The money to run the Australian health system is raised from households, families and individuals, principally through two mechanisms: taxation and voluntary contributions. This money flows via government, private health insurers and by consumer purchases directly through to providers and suppliers of health services (doctors, nurses, allied health staff, hospitals, pharmaceutical companies, pathology companies) who, in turn, provide services back to families and individuals.

Hence, the issues of interest to us can be considered across two major dimensions:

- how we raise money, or the financing of the health system; and
- how we spend money, or the funding models we use to pay for health services.

13.1 Financing choices

The choices open to us in regard to financing include: how much we choose to spend on health services, and where the money is raised from.

13.1.1 How much do we spend on health now?

In Australia, we currently spend $94 billion on health services – about $4500 for every man, woman and child. As a nation, health spending accounted for 9 per cent of gross domestic product in 2006–07. If we compare this with a decade ago using today's prices, we spent $58 billion in 1996–97 with health services accounting for 7.7 per cent of gross domestic product.[2]

Given the growing burden of chronic disease, technological advances that mean we can treat more people for more conditions, and an ageing population, it is hardly surprising or front-page news that health services represents a bigger share of our total spending.

If we compare our health spending with other countries, Australia's spending is almost exactly what you would expect it to be given the size of our economy and our relative wealth. There is a well-known relationship that, as the wealth of a country increases, it spends more on health services as a share of gross domestic product.[3]

13.1.2 How much are we going to spend in the future?

Given that our role is to develop a long-term health reform plan, we commissioned some expert work on the projections for future health spending over the next 25 years.[4]

These projections identify how we can expect future health and aged care spending to grow, assuming 'business as usual'. The factors that have been used to develop the projections on future health and aged care spending comprise:

- ageing;
- population growth;
- changes in the pattern or rate of various diseases;
- changes in the volume of health services provided for treated patients (a measure of the 'intensity' with which care is provided);

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[2] Australian Institute of Health and Welfare (2008), Health expenditure Australia 2006–07 (Australian Institute of Health and Welfare: Canberra).

[3] P Gottret and G Scheiber (2006), Health financing revisited: a practitioner's guide (World Bank: Washington).

[4] J Goss (2008), Projection of Australian health care expenditure by disease, 2003–2033, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

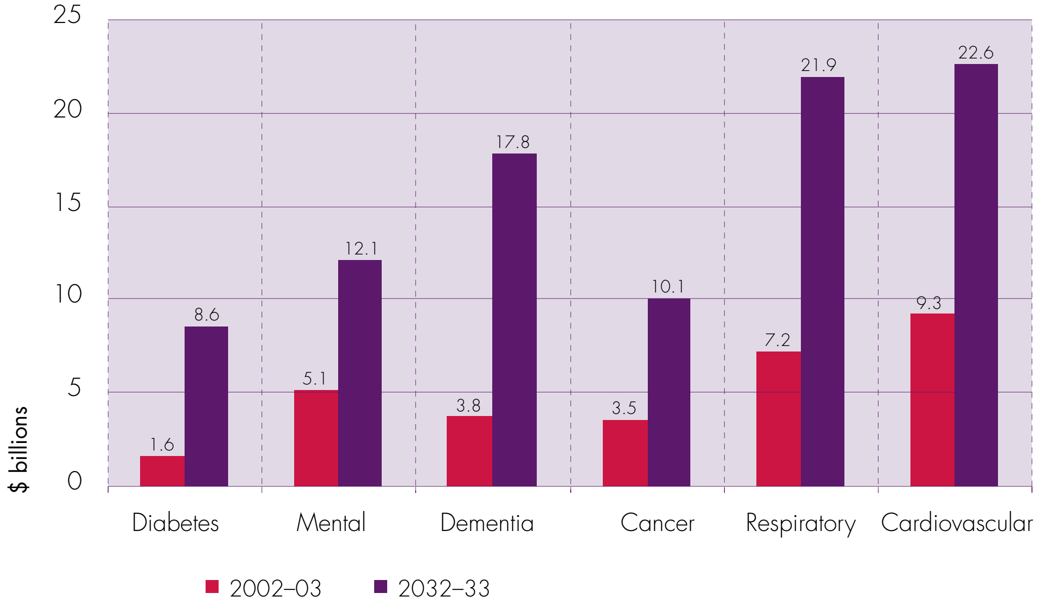
- changes in the share of the population receiving treatment for particular conditions (a measure of the 'coverage' or comprehensiveness of treatment); and
- changes in spending on health relative to general inflation.

Over the next 25 years health and aged care spending will increase to $246 billion – about one-quarter of a trillion dollars

These projections indicate that, over the next 25 years, health and aged care spending will increase to $246 billion – about one-quarter of a trillion dollars. By 2032–33, health and aged care services will consume 12.4 per cent of gross domestic product.

While health and aged care spending is expected to almost triple from 2002–03 to 2032–33, spending on some conditions will increase even more rapidly (see Figure 13.1). Chronic diseases will dominate the growth of our future health and aged care spending. Spending to treat people with Type 2 diabetes is estimated to increase by 520 per cent, for people with dementia by 364 per cent, and for people with respiratory conditions by 205 per cent.

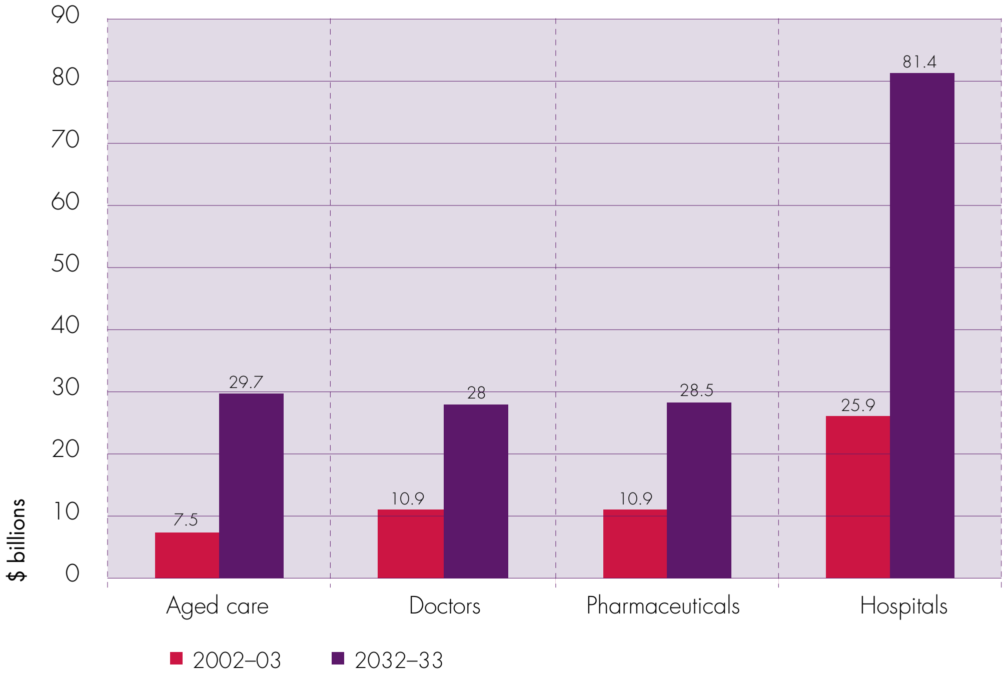
Figure 13.1: Spending on chronic diseases will grow significantly over the next twenty-five years



Source: J Goss (2008), Projection of Australian health care expenditure by disease, 2003–2033, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

If we continue with business as usual, the fastest growing areas of spending will be for acute services, such as hospitals and aged care (see Figure 13.2). Changing how much, and where, we spend will require greater investment in prevention and primary care, coupled with a real commitment to keeping people healthy.

Figure 13.2: The fastest growing areas of spending will be for aged care services and hospital admissions



Source: J Goss (2008), Projection of Australian health care expenditure by disease, 2003–2033, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

Reform direction 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.
- 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.

13.1.3 How should we raise the money for our health care system?

The question of 'who should pay' for health services has no easy answer. Ultimately, all spending is from households, whether it is raised through taxation, purchased through private health insurers or paid for directly by individuals.

In general terms, Australia's mix of health financing is often thought of as two-thirds flowing via government and one-third flowing from non-government (or private) sources. If we break down the $94 billion we spent on health services in 2006–07[5]:

- $39.9 billion (42.4 per cent) came from the Commonwealth Government;
- $24.7 billion (26.2 per cent) came from state/territory and local governments;
- $16.0 billion (17.0 per cent) came from individuals directly;

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[5] Australian Institute of Health and Welfare (2008), Health expenditure Australia 2006–07 (Australian Institute of Health and Welfare: Canberra).

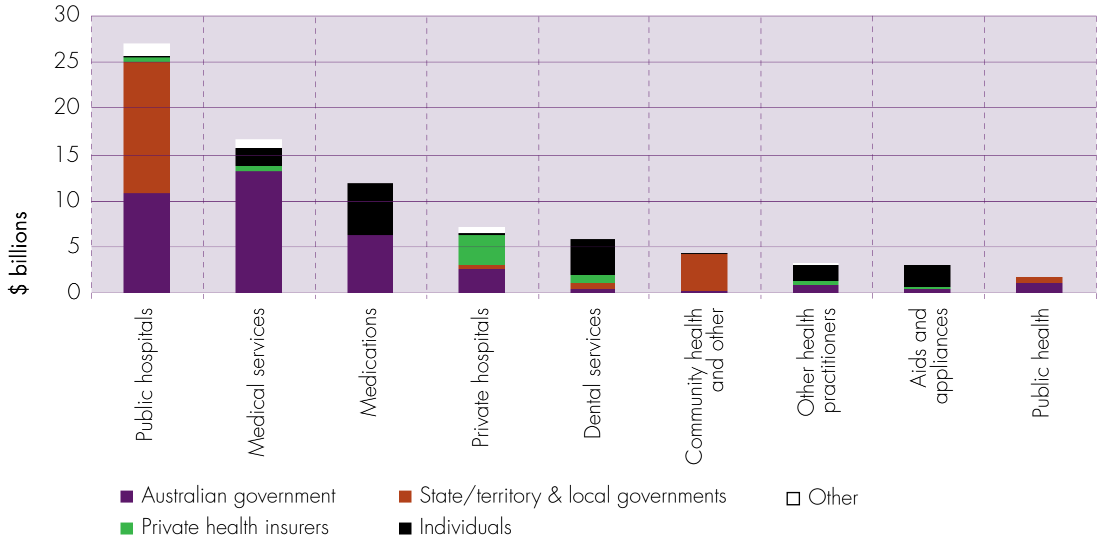
- $6.9 billion (7.3 per cent) came from private health insurers; and
- $6.7 billion (7.1 per cent) came from other payers (such as workers' compensation and transport accident insurance schemes).

So, the one-third of non-government or 'private' funding for health services actually comes from many sources. About one in every six dollars spent on health services in Australia is paid for directly by individuals; private health insurers and other payers (accident compensation schemes) each contribute about one in every fourteen dollars. In thinking about the 'public–private' mix of health financing, it is important to recognise that the 'private' contribution is largely paid directly by households, not via private health insurers or other third-party payers.

However, the composition of who pays varies considerably across different types of health services (see Figure 13.3). The Australian Government is the 'majority' funder for medical services (78.3 per cent), for public health (58.4 per cent) and for medications (52.7 per cent). State and territory governments are the majority funder for community health (83 per cent) and public hospitals (53.2 per cent). Private health insurers are the largest funder for private hospitals (46.6 per cent).

Individual households contribute very substantial amounts directly out of their own pockets for aids and appliances (contributing 74.4 per cent of total costs), for dental services (67.3 per cent) and for other health practitioners (such as physiotherapists or dieticians) (52.7 per cent). Hence, governments' priorities about what to fund (and what not to fund) determine what health costs must be met directly by Australian households.

Figure 13.3: Governments, individuals and private health insurers have set different priorities in paying for health care services



Source: Australian Institute of Health and Welfare (2008), Health expenditure Australia 2006–07 (Australian Institute of Health and Welfare: Canberra).

The choices we make about how to raise funding for health services – through taxation or voluntary payments – have consequences

■ The choices we make about how to raise funding for health services – through taxation or voluntary payments – have consequences.

The greater the level of taxation in a country, the less money households can spend on their individual choices between housing, travel, food and health care. Greater levels of taxation are argued to reduce individual incentives to work overtime and invest in new businesses. On the other hand, the incidence of taxation is progressive: wealthier households pay more tax and indeed a greater proportion of their income than poorer households. Taxation serves as a means of making

Australia a more equitable society by redistributing income from wealthier households to poorer households. Funding health services through taxation also serves to redistribute costs from sicker people to healthier people, similar to the way in which community rating works for privately insured people. Taxation redistributes money over a person's life cycle: from when they are in employment to when they are older and generally have higher health needs.[6]

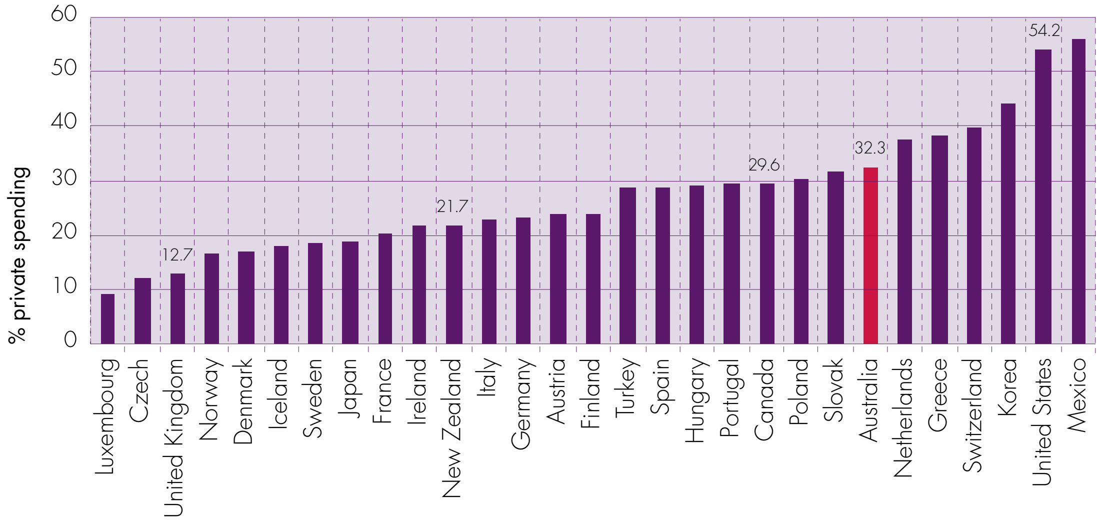
Voluntary payments (whether through health insurance or as out-of-pocket costs) have different characteristics. On the one hand, they allow households to directly express their preferences for what health services they want to purchase, rather than relying solely on the priorities of governments. On the other hand, voluntary payments are generally less equitable. Even though wealthier people spend more on health services and health insurance, this is generally a lower proportion of their income than for poorer people. Wealthier people are thus able to buy more access to health services but spend a lower proportion of their income for it.

The balance between taxation and voluntary payments (either through health insurance or through out-of-pocket costs) is essentially a political choice. How much does Australia want to raise taxation? How much choice does Australia want to provide households to set their own spending priorities?

There is no 'right' mix of government and private funding of health services. We note that most countries use a mix of government and private funding to pay for health services (see Figure 13.4).

- Most countries use a mix of government and private funding to pay for health services

Figure 13.4: The share of private sector financing varies across countries



Source:	Organisation for Economic Cooperation and Development (2008), Health data 2008: Frequently requested data, at: http://www.oecd.org/document/16/0,3343,en_2649_33929_2085200_1_1_11,00.html.
Note:	Data are for most recent year (2006), with the exception of Turkey (2005), New Zealand (2003), Denmark (2002) and the Netherlands (2002).

Australia, with more than 30 per cent of health spending through private sources, ranks at the high end of private spending internationally. We also note that the international trend is for a convergence to the mean. That is, countries with historically high public financing (such as the United Kingdom) are increasing their private spending share. And countries with historically high private financing (such as the United States) are increasing their public spending share.

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[6] N Barr (2001), The welfare state as piggy bank: information, risk, uncertainty, and the role of the state (Oxford University Press: Oxford).

The use of co-payments needs to be evidence-based and have regard to the high contributions already made directly by many Australian families

In this context, and in light of the already high level of out-of-pocket payments faced by Australian households (see next section), we do not believe that significantly expanding the use of co-payments represents the magic bullet solution to meeting future health service needs. As discussed in Chapter 1, we are open to the evidence-based use of price signals, including the potential use of positive incentives or bonuses to encourage healthy behaviour. The use of co-payments must recognise the inability of many people to distinguish between medically necessary and discretionary services, together with the equity concerns for some population groups. We also believe there is considerable scope for tidying up the existing hotchpotch of safety nets (see next section) that now include different co-payments across different health services. As a general principle, however, the use of co-payments needs to be evidence-based and have regard to the high contributions already made directly by many Australian families to the costs of health care services.

Australia's mix of public and private financing is generally regarded as one of the strengths of our health system. We believe that this balance should be maintained.

Reform direction 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.

In formulating this reform direction, we remain open to options that result in changes to the mix of financing (government, private health insurance, individuals) for particular types of health services. For example, we raise concerns about the costs borne by individuals for some health services (such as dental care and aids and appliances) in the next section. We also want to make clear that maintaining a balanced mix of health financing is not a passive process, but will involve ongoing choices about what services should be funded through what financing stream. This requires balancing key goals such as equity and affordability with the benefits of a mixed public-private system including choice, innovation and investment.

Given that decisions about the level of taxation and private financing of health services must be made at a whole of community level, we support mechanisms to encourage greater community participation in setting health care priorities.

Other than blunt expression through political processes, Australia does not have systematic ways for tapping the views of consumers about levels of health spending, and the purposes for such spending. Many groups and individuals expressed very strong support for greater involvement of the community and health professionals in both contributing to health reform and shaping the priorities for a health system of the future. For example, the Australian Medical Association argued that:

> *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 view of patients and providers.*[7]

In line with our principle of public voice and community engagement, we believe there needs to be strengthening of mechanisms to facilitate broad, informed public debate about the value of health, how much we spend on health care and what we should spend it on. Informed consumer deliberation (such as citizen juries) could thus occur about what are the service expectations of what should be funded from the public purse.

Reform direction 13.3

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

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[7] Australian Medical Association (2008), Submission 445 to the National Health and Hospitals Reform Commission.

Mechanisms to strengthen community participation are also discussed in Chapter 12.

13.1.4 Is the level of spending on health services by Australian households reasonable?

The high costs faced by some households in paying for health services were mentioned as one of the barriers to access in some of our consultations with community groups and also in the submissions we received.

> *With Australia having some of the largest out of pocket expenditure payments in the world, a decision to review and initiate a family focused payment system is paramount.*[8]

Accordingly, we commissioned the National Centre for Social and Economic Modelling (NATSEM)[9] to analyse the most recent available data (2003–04) on household spending to identify:

- How much are Australian households spending on health services directly out of their own pockets?
- What types of health services are particularly contributing to high out-of-pocket costs? Are some types of households particularly hard hit by spending on health services?
- Is it getting worse or better? Are people spending more or less on health services relative to other types of household expenses?

■ Spending on health care was a 'big ticket' item among Australian households

NATSEM found that spending on health care was a 'big ticket' item among Australian households. Among households who paid for health services, the average weekly spending was $50.64, equal to 5.2 per cent of total household spending.

Paying for private health insurance premiums represented the largest share of spending by households on health costs. Privately insured households spent, on average, $29.90 each week or 3.3 per cent of total household spending. In comparison, households allocated 3.7 per cent of their total spending to the cost of education (primary, secondary and higher education) and 3.8 per cent of their total spending for fuel and power. Hence, private health insurance represents a significant investment choice for many Australian households.

Dental care represents another major out-of-pocket cost for many Australian households, accounting for 3.1 per cent of total household spending among households with dental costs. However, patterns of spending by different types of households suggest that there are affordability issues for some households in being able to access dental care. So:

- Low income households were much less likely to have spending on dental care (only 11 per cent of low income households) than high income households (27.2 per cent).
- When low income households did pay for dental care, it accounted for 8.2 per cent of their total household spending. That is, one in every twelve dollars of all household spending by low income families went to pay for dental care.

The high costs for many households in getting access to dental care are one of the contributing factors that have led us to propose (see Chapter 11) the development of a new funding model to provide universal coverage for dental services.

Some types of health services are used by only a small share of the population, but represent a significant cost burden for these people. One such category is therapeutic appliances which includes items such as wheelchairs, orthopaedic braces, artificial limbs, orthotics and hearing aids. NATSEM found that:

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[8] Cancer Voices Australia (2008), Submission 53 to the National Health and Hospitals Reform Commission.

[9] 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.

- While only 1.4 per cent of households had spending on therapeutic appliances, these households spent $91.09 a week or 5.1 per cent of their household spending on these items.
- The highest weekly costs for therapeutic appliances were experienced by non-insured households who spent $243.93 a week.
- The costs were also very high among households with a Concession Card at $164.51 a week.

Health costs for Australian households increased by 15 per cent between 1998-1999 and 2003-2004

■ NATSEM also examined how household spending on health services had changed over time. It found that health costs for Australian households increased by 15 per cent between 1998–1999 and 2003–04. Health care is consuming a growing share of family budgets – up from 4.5 per cent in 1998–99 to 5.2 per cent in 2003–04 – and hence is displacing other spending priorities of households. And it is apparent from the analysis that some households are facing very high costs, with some types of health services causing major affordability issues for some households.

This uneven distribution of health costs across households reflects the funding priorities of governments, over time and at all levels, about what services should be subsidised from the public purse. Our universal programs – public hospitals, the MBS and PBS – have kept health costs relatively affordable for these services. But the same is clearly not true for some other health services.

Currently, there is a patchwork of funding programs and safety nets.

> *The safety net scheme for medical benefits is on an individual basis; for pharmaceutical benefits, by contrast, the safety net is on a family basis. Then while safety nets operate [over] calendar years, there is a 20 per cent tax rebate for medical expenses above $1500 in a financial year, with different definitions of what qualifies as a medical expense. And that's before mentioning concessional arrangements.*[10]

There are also a range of safety nets and programs designed to protect people who are likely to face high health costs. Some national examples include the National Diabetic Services Scheme and the Continence Aids Assistance Scheme. State governments also offer some assistance towards the costs of patient transport and aids and equipment. The effectiveness of some programs is clearly questionable. The high costs of patient transport have been the subject of a recent Senate inquiry[11] and were frequently raised with us during our consultation meetings.

The patchwork of safety nets, including different eligibility rules and requirements for different services, is not compatible with a high-performance, productive health system, where the right services are provided to the right person at the right time.

In our discussion on strengthening and reforming primary care (see Chapter 2), we have referred to the need to develop new funding arrangements and broaden the scope of services that are eligible for public funding. We need to be clear that this does not necessarily mean adding other services to the current Medicare system. (Further work will also be required on the appropriate mix of funding by individuals, private health insurers and government for any new health services.) What it does mean is thinking creatively about the range of services that might receive some public funding. Health costs should not distort sensible service provision, nor impede access to the right care for Australian families.

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[10] I McAuley (2008), Submission 269 to the National Health and Hospital Reform Commission.

[11] Senate Community Affairs Committee (2007), Highway to health: better access for rural, regional and remote patients, at: http://www.aph.gov.au/Senate/committee/clac_ctte/completed_inquiries/2004-07/pats/report/index.htm

Reform direction 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.

13.2 Funding choices

The second part of the 'money cycle' relates to the way in which funding is allocated to pay for health services. We separately consider funding decisions relating to recurrent and capital spending.

13.2.1 Making choices about recurrent spending

There are essentially three main ways in which funding can be distributed:

- payments related to the number of consumers that are cared for over a period (capitation or per-capita payments). One example of this type of payment mechanism is the New South Wales resource allocation formula where Area Health Services are funded predominantly on the basis of their population, with adjustments for factors that might contribute to higher health service needs and costs.
- payments based on the number of services that a health professional or service provides (payments for service that are sometimes called 'activity-based payments'). Examples of activity-based payments include fees paid under the Medicare Benefits Schedule, payments by private health insurers for physiotherapy and dental services and casemix payments used by many states to pay for public hospital services.
- other payments (such as grants, block payments or salaries) that may be determined by policy choices, history, or some other negotiated basis. An example includes a grant to a remote health agency to provide a range of health services. Another example is an 'availability' payment to a public hospital related to keeping an emergency department open, irrespective of how many patients are treated.

The first two of these funding approaches are closely linked, as total expenditure in a population is related to the size of the population multiplied by the services provided per head multiplied by the cost per unit of service.

Different types of approaches to funding health services have different incentive effects. Choices about the allocation of funding need to consider the best type of funding model to achieve the particular objectives being sought.

Under a capitation funding model, a health service has a strong incentive to manage both the volume of services provided to each person and the cost per unit of service. Capitation funding can provide a strong incentive to undertake more prevention and early intervention to keep people healthy. A potential risk with capitation payments is that necessary health services may not be provided. To counter this risk, capitation payments need to be accompanied by clear benchmarks for patient outcomes, access or other measures that ensure necessary care is provided.

- Capitation funding can provide a strong incentive to undertake more prevention and early intervention to keep people healthy

As funding under a capitation model is linked to a whole population, there is less focus on prescribing the services or health programs that should be funded. Some groups support more use of capitation funding models (or block grants) to break down multiple funding streams:

> *Community health centres in Victoria already attempt to provide integrated multidisciplinary care. They can have up to 40 different funding schemes from Federal, State and Local Government.*

> *Apart from the bureaucratic nightmare this presents to the organisation in terms of multiple accountability measures and funding applications, it is a further barrier to patient based care. One patient fits the criteria for a certain type of service, and needs a small amount and can easily get it. Another patient desperately needs the same service but doesn't fit the criteria. The care given is not patient-centred, it's program centred.*[12]

Capitation payments may also be considered as a type of payment that relates to providing all the necessary care for a person related to a particular condition over a specified time. Depending upon how capitation payments are made, they may also support greater choice if consumers can take 'their' capitation payment and receive health care from the providers of their choice. For example, the Australian College of Midwives provided information to us on the funding model for maternity care in New Zealand where each pregnant woman can elect a Lead Maternity Carer.[13] Under this approach, the health care provider is able to access government funding that covers the 'course of care' – antenatal and pregnancy care – for each enrolled woman. Capitation payments may also better serve the needs of some patients with chronic and complex conditions, as health professionals and patients may have greater flexibility in accessing the 'right' services for individual patient needs.

A major feature of many activity-based payments is that they drive greater efficiency and productivity

Activity-based payments have a different set of incentives, although there is considerable variety in how they can be designed and operate. A major feature of many activity-based payments is that they drive greater efficiency and productivity.

The examples given earlier of activity-based funding payments (to hospitals per patient treated, payments for each medical visit) are somewhat different in kind. A payment for a medical visit under the MBS generally reimburses only the interaction between the doctor and patient. On the other hand, a payment for each hospital patient treated involves the 'bundling' of the range of services involved in that hospital stay. Services such as pathology, radiology, and indeed each day of stay, are all bundled together with the appropriate surgery or medical care and the hospital receives a single composite payment for all these services. In this way a hospital has a financial incentive to manage the use of pathology services, for example, as excess investigations do not attract any additional funding, thus driving efficiencies in care.

Bundling approaches to activity-based funding can also be applied to ambulatory care. In Victoria, funding arrangements for public hospital outpatient services involve the bundling of all investigations for 30 days on either side of the outpatient visit. Again this provides an incentive for the clinician seeing the patient as an outpatient to determine carefully what investigations are necessary.

Similar approaches can be adopted in community care with a payment to a general practitioner or other primary health care professional to manage investigations of a patient around a visit window. For example, an activity-based payment could be made relating to the care of patients over a defined period of three or twelve months. These arrangements could build on the payments for care coordination already incorporated in the Medicare Benefit Schedule. As already discussed in Chapter 2, such an approach would respond to the concern that existing fee-for-service payments are not the best approach to funding primary health care for people with chronic or complex needs.[14]

The broader the window of care which is incorporated in an activity-based payment and the greater scope of services that are bundled into that payment, the more the activity-based payment begins to have characteristics of a capitation payment. So, although activity-based payment and capitation are sometimes considered as alternative funding models, it may be better to consider them as points on a continuum rather than simple alternatives.

A risk that needs to be managed with activity-based funding is ensuring that it covers all the major aspects of health services, not only patient care. A frequently raised issue among our submissions was that clinical education was being squeezed within a busy service delivery environment that

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[12] Doctors' Reform Society (2008), Submission 78 to the National Health and Hospitals Reform Commission.

[13] Australian College of Midwives (2008), Submission 27 to the National Health and Hospitals Reform Commission.

[14] Australian Association of Occupational Therapists (2008), Submission 23 to the National Health and Hospitals Reform Commission.

was focused on treating more patients. For example, the Australian Medical Students Association argued for 'quarantined investment in infrastructure for education and training', as well as wanting to expand clinical training capacity in rural areas and across a broad range of settings such as community-based and private sector care.[15]

While we examine workforce issues in more detail in Chapter 14, we agree with the importance of protecting teaching time and argue that one way to achieve this objective is through explicitly funding clinical education. We believe that activity-based payments should be made for clinical education activity (both undergraduate and postgraduate education), in addition to direct patient care. Clinical education can be funded on the basis of days of undergraduate clinical education provided, or number of postgraduate trainees employed within an organisation. If any essential element of service provision is not appropriately funded, it runs the risk of not being provided.

Activity-based and capitation payments are generally described as being related to the care of patients. Care payments can also be moderated or supplemented by additional payments related to other aspects of the interaction between the patient or consumer and the health care professional. Bonuses or penalties can be introduced relating to the timeliness of care (waiting times for elective surgery, for example) so the additional payments (bonuses) or payment reductions (penalties) can be made for those patients seen (or not seen) within a specified time period.

Additional 'performance related' payments could also be made for other policy goals. These might include payments related to outcomes or processes associated with clinical quality. Providers who undertake a higher level of preventive interventions (ensuring that all patients seen within their practice are appropriately immunised) may attract additional payments; adherence to clinical markers, designated as part of good care, might also be rewarded financially. These 'pay for performance', or outcome-based payments, are used with increasing frequency in health systems internationally[16] and should be implemented in Australia (see Figure 13.5).

■ 'Pay for performance', or outcome-based payments, should be implemented in Australia

Figure 13.5: Queensland is beginning to use 'pay for performance' to achieve better outcomes for public hospital patients

Queensland Health has recently introduced a pay for performance element as part of its funding for public hospitals. Under the Clinical Practice Improvement Payment system, public hospitals are able to receive additional payments if they meet certain clinical indicators.

The Clinical Practice Improvement Program involved 12 months of clinical consultation to ensure that the clinical indicators were evidence-based and acceptable to clinicians. Other key design features included ensuring that bonus payments were able to flow through to the actual clinical units responsible for achieving required performance on the clinical indicators.

The first set of clinical indicators that are being linked to performance payments cover areas including:

- *timely treatment by a community mental health professional for patients with schizophrenia after they are discharged from a hospital;*
- *provision within 48 hours of antiplatelet therapy for patients with an acute stroke;*
- *completion of a discharge medication record for patients leaving hospital with evidence of communication back to the patient's general practitioner or residential aged care facility.*

The performance payments related to meeting these clinical indicators have been set at about 1–3 per cent of the price otherwise paid by Queensland Health for treating relevant hospital patients. As this new payment mechanism only took effect in June 2008, data are not yet available on its impact.

Source: S Duckett, S Daniels, M Kamp and colleagues (2008), 'Pay for performance in Australia: Queensland's new Clinical Practice Improvement Payment', Journal of Health Services Research and Policy, 13(3): 174–177

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[15] Australian Medical Students' Association (2008), Submission 503 to the National Health and Hospitals Reform Commission.

[16] P Gross (2008), Submission 448 to the National Health and Hospitals Reform Commission.

We note that reform of payment arrangements focusing on the pay for performance concept was suggested in several submissions. This concept has many meanings and can include both the use of incentives or penalties linked to the standard of performance. For example, the Australian Health Insurance Association (AHIA) has suggested that existing default benefit payments made by private health insurers could be changed:

> *… to promote real competition and ultimately remove the disincentives for providers offering a lower standard of care and/or less optimal outcomes than their peers.*[17]

AHIA notes that payment for performance, based on quality and safety metrics, can only be implemented successfully if there is robust information about patient outcomes. Other submissions focused on using payment reform to provide incentives for the right type of care. For example, Paul Gross suggested an array of new payments to encourage 'systemness' including: no patient co-payments for effective preventive services; higher payments from Medicare and private health insurers for high quality medical and hospital care; and new incentives for care outside hospitals and care provided online.[18]

Pay for performance raises complex issues about what is the 'base' level of quality and safety that consumers should be able to expect from health care. Do we pay 'extra' for 'higher' quality? Should funders (whether governments, private health insurers or individuals) have the right to withhold payment for poor quality care? And what constitutes unacceptably low quality care for which payment should be withheld (for example, amputation of the wrong limb)? To date, these issues have been little explored in Australia.

Moving now to the issue of capital costs, we believe it is important to incorporate the appropriate cost of capital in all recurrent funding arrangements. This applies to all activity-based payments, including casemix payments for hospitals, new payments for sub-acute services and payments for primary health care services. This relates to how health services are able to cover the replacement or depreciation costs, not major expansions in physical infrastructure which require additional new capital, as further discussed below.

We further note that governments have already identified a move to greater use of activity-based funding as a way of improving the overall efficiency of public hospitals. Our view is that a mix of different funding models will need to be used across the whole health system. Some funding approaches are better suited to certain types of health services or certain settings.

Reform direction 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 case mix 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.
- 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.

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[17] Australian Health Insurance Association (2008), Submission 480 to the National Health and Hospitals Reform Commission.

[18] P Gross (2008), Submission 448 to the National Health and Hospitals Reform Commission.

Irrespective of the funding model used, we also heard frequently about the need to ensure that funding for health services was appropriately adjusted to reflect different cost structures or access problems for under-served populations. Issues relating to ensuring adequate funding for rural and remote populations are considered in more detail in Chapter 9. Here, we emphasise that funding models cannot be a 'one size fits all' approach, but will need to recognise the higher costs of meeting the needs of certain populations.

Reform direction 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.

13.2.2 Making choices about capital spending

Almost all the policy and media focus in health is notionally about the recurrent costs of health services. For example, some of the issues that are frequently raised include: How much are public hospital budgets going to grow? Are we spending enough on mental health services? How much are fees (and government benefits) for general practitioner services increasing? What is the growth in private health insurance premiums?

Apart from decisions made by state governments about building or rebuilding an iconic public hospital (such as a children's hospital), we rarely hear about the 'Goldilocks' problem of capital spending: whether we are spending too much, just the right amount, or too little on the capital infrastructure of our health care services. We received a few submissions raising issues about the adequacy of investment in medical technology and equipment. For example, Engineers Australia argued:

> *A 'typical' public teaching hospital will house clinical equipment with a value in excess of $50 million. Keeping this equipment current demands that around $5 million per annum be spent on capital replacement programs. This rarely occurs, resulting in crisis replacement often via truncated procurement processes that do not necessarily deliver value for money … Poor funding models also often result in piecemeal or ineffectively staged replacement programs.*[19]

Part of the reason for this lack of focus on capital spending is that it is actually very difficult to accurately measure the current level of investment in health capital (and even harder to estimate whether this is the 'right' level).

The Australian Institute of Health and Welfare reports that in 2006–07 we spent $5.3 billion on health facilities and equipment – equal to 5.6 per cent of total health spending.[20] But when we begin to 'unpack' this spending, it becomes obvious that this reported level of spending on capital conveys only part of the picture.

■ In 2006-07 we spent $5.3 billion on health facilities and equipment – equal to 5.6 per cent of total health spending

Of the $5.3 billion of reported capital investment in health in 2006–07:

- $2.98 billion (56 per cent) was spent by the non-government (or private) sector.
- $2.18 billion (42 per cent) was spent by state, territory and local governments.
- $132 million (2 per cent) was spent by the Commonwealth Government.

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[19] Engineers Australia (2008), Submission 80 to the National Health and Hospitals Reform Commission.

[20] Australian Institute of Health and Welfare (2008), Health expenditure Australia 2006–07 (Australian Institute of Health and Welfare: Canberra).

This pattern of capital spending is apparently quite different to the distribution of total spending on health care services that we reported earlier in Section 13.1.3. However, there are several important limitations and qualifications with the available data on capital spending.[21]

First, most of the capital spending in health by the non-government sector represents investment in private hospitals. However, the reported amount of $2.98 billion on 'health' capital spending by the private sector is actually likely to include significant capital spending on aged care services. This means that it is not possible to directly compare the levels of recurrent and capital spending within the health sector. In addition, the private capital spending is not reported by 'source of funding', again making it difficult to examine relative spending on capital and recurrent by government and non-government sectors.

Second, most of the spending by state governments is on state-run services such as public hospitals and community health services. These data are the most accurate in capturing 'dedicated' or separate funding of capital on health services.

Third, the apparently low level of spending by the Commonwealth Government reflects that:

- In general, it does not directly operate health services but funds health services that are privately delivered (such as general practice, pharmacy and radiology).
- The benefit paid by the Commonwealth Government for each of these health services includes a component for the cost of capital, and so some of the private capital spending is, in fact, sourced from Commonwealth payments for services provided in the private sector. Unlike state government funding of public hospitals, the Commonwealth Government does not separate out capital from recurrent costs, but pays a single price. (The same holds true for payments by private health insurers to private hospitals.)
- The Commonwealth makes a small number of grants ($24 million in 2006–07) that are of a capital nature, usually to non-government organisations and sometimes to other levels of government (such as state, territory and local governments). In addition it has its own capital expenditure ($108 million in 2006–07) for its own purposes (largely information technology and property, plant and equipment expenditure to support administration).

Fourth, there are differences between how the public and private sectors obtain capital assets: taxation and other accounting issues place different incentives on the two sectors in terms of the relative attractiveness of direct investment in capital compared to leasing (or rental) arrangements. This in turn affects what capital acquisitions are reported compared to what capital assets are available to be used.

These differences in how we measure and report data on capital investment in the health system make it very challenging to identify relative spending by government and non-government sectors, and whether we have 'got it right' in terms of the overall existing level of investment in health capital.

With regard to long-term reform of the health system, we would argue that there are two important messages in relation to future capital investment.

First, we believe that the cost of capital (which would allow health services to maintain, repair and replace existing equipment and infrastructure) should be included in the 'price' or funding payments made by all payers of health services. This is currently the case with some payments made by the Commonwealth for health services (such as general practice) and payments made by private health insurers for all private health services (such as private hospitals). The same should occur with payments from all funding sources for health services (for example, activity-based payments for public hospitals). These payments should be neutral as to whether the recipient is a public, non-government or private for-profit provider.

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[21] J Goss, Personal communication with the National Health and Hospitals Reform Commission.

Second, we anticipate that some of the reform directions proposed elsewhere in this report will have capital implications and require the investment of new capital, at least on a transitional or 'hump' funding basis. The reality is that the majority of capital spending in both the public and private sector has historically been directed towards acute hospitals, with lower investment in other community-based services. This dilemma was described in one of our submissions as follows:

> *Each State and Territory Government has been compelled to use as much of its own funding and available Commonwealth funding for health in sustaining acute health services. Desirable high priority community based services, preventative and health promotion, some mental health and rehabilitation services have competed with acute and emergency services for funds, often with less success. With a focus on obtaining sufficient funds to meet the immediate needs of health care for patients presenting at hospitals, State and Territory governments have had limited opportunity to systematically invest in service delivery.*[22]

We believe that additional capital investment will be required to build the reform elements of a future health system. We note that the Commonwealth Government has recently established the Health and Hospitals Fund to support strategic investments in health. Moreover, we note that additional capital investment may also be funded through private equity sources. The extra capital required does not all have to be sourced directly through governments.

Reform direction 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.
- 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.

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[22] R Kerr (2008), Submission 312 to the National Health and Hospitals Reform Commission.

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

Key messages

- The dedication, diversity and dynamism of our health workforce are major strengths of the Australian health system. We can, and should, be legitimately proud of the critical contribution that our well-qualified health professionals make to helping us achieve better health.
- One in every eleven people (8.6 per cent) is employed in the health sector. Our health workforce includes almost 600,000 health staff and about another 275,000 support staff. About half the health workforce (300,000) are nurses. Outside the health workforce, about 470,000 Australians play a vital role as 'informal carers'.
- Despite these strengths, we face major challenges relating to the number, distribution, training and demographics of our health workforce, both now and into the future. This was seen by many as the major problem facing the Australian health system. We need to act now to ensure we have a sustainable quality health workforce into the future.
- Our health workforce is ageing. With the exception of nurses, there is much less access to most health professionals in rural and remote Australia. The demands of an ageing population and the growth of chronic disease will place greater pressure on an already strained health workforce.
- Australia is not currently self sufficient on a net basis across all categories of health professionals.
- Existing professional boundaries restrict our ability to use fully the skills of the current health workforce.
- There is a disconnect between the priorities of health services and the need to educate and train the next generation of health professionals.
- In a rapidly changing world of practice, we need to find new ways to educate our future health workforce.

Our reform directions

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.

14.1 Introduction

Australia has a highly qualified, dynamic, diverse and dedicated health workforce – the people who care for and treat us are a key strength of the health system. Working individually or as part of a team they provide the myriad of health services that Australians expect.

■ Australia has a highly qualified, dynamic, diverse and dedicated health workforce – the people who care for and treat us are a key strength of the health system

Given their critical role, it is not surprising that there have been several major studies and reports that identify challenges for Australia's health workforce, perhaps the most notable being the Productivity Commission's report in December 2005.[1] The challenges we face are not unique. Like the rest of the world, Australia is looking for answers to tackle expected increases in demand for health services and projected workforce shortages.

> *Australia is fortunate in having a workforce that is highly skilled and dedicated to caring for patients notwithstanding the many systemic impediments faced in the performance of their roles. In the face of increasing global competition for health professionals, the ongoing sustainability of our workforce is of vital importance.*[2]

Australia, through the Council of Australian Governments (COAG), has endorsed a vision for a future health workforce and established the National Health Workforce Taskforce to develop strategies to meet this vision:

> *Australia will have a sustainable health workforce that is knowledgeable, skilled and adaptable. The workforce will be distributed to achieve equitable health outcomes, suitably trained and competent. The workforce will be valued and able to work within a supportive environment and culture. It will provide safe, quality, preventative, curative and supportive care that is population and health consumer focused and capable of meeting the health needs of the Australian community.*[3]

In keeping with our principle of 'providing for future generations', we have explored ways for the health workforce and health system to adapt to future health needs.

14.2 The Australian context – our health workforce

It has been estimated that the health workforce makes up just over 8.6 per cent of the total workforce[4] and is the second largest workforce group.[5] Health is therefore a vital part of our national economy – 'producing health' helps us to grow a stronger economy.

At August 2006[6], 593,300 people were working in a health occupation such as a doctor, nurse, or dentist. A further 276,000 people work in the health services industry as cleaners, clerks and

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[1] See also, for example, The Blame Game: Report on the Inquiry into Health Funding, House of Representatives Standing Committee on Health and Ageing (2006); Report on the Audit of Health Workforce in Rural and Regional Australia (2008) (Commonwealth of Australia).

[2] Catholic Health Australia (2008), Submission 57 to the National Health and Hospitals Reform Commission.

[3] National Health Workforce Strategic Framework (2004), at: www.nhwt.gov.au/theframework.asp

[4] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

[5] Australian Bureau of Statistics (2006), Census of Population and Housing, at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/ProductsbyCatalogue/A6D6129396973B5ACA257306000D4DB9?OpenDocument

[6] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

chefs, for example. Further still, there are 472,500[7] people across Australia who care for family and friends in the community who would otherwise need to be cared for in the health and aged care sector. We heard many times about the vital role of informal carers, usually family members:

> *The availability of Australia's carers and their ability to continue their caring role is therefore critical to the long-term sustainability of the Australian health and community care systems.*[8]

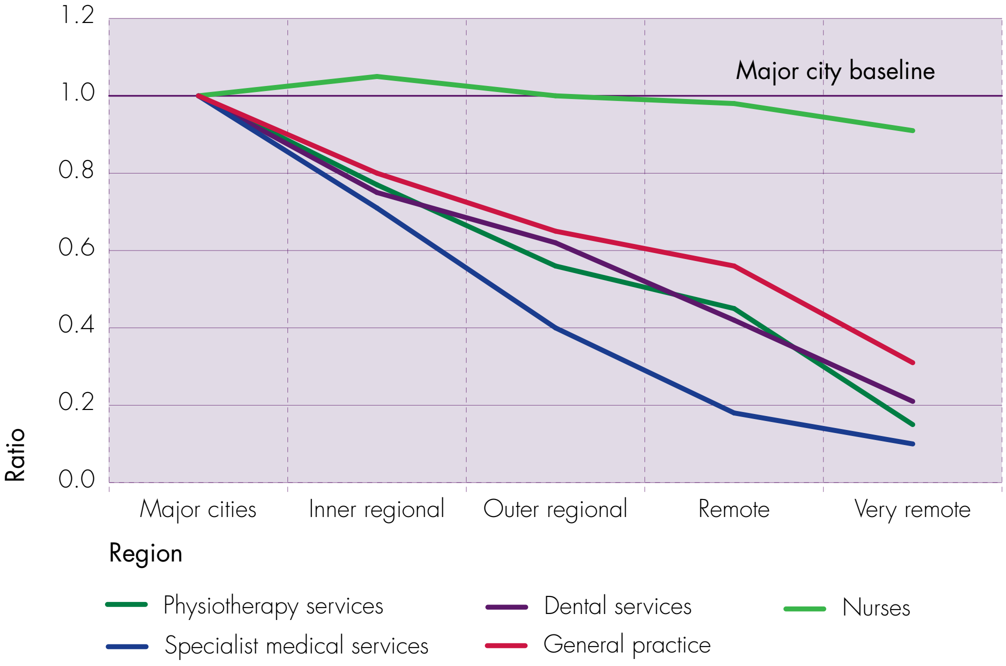
In 2006[9], there were 298,100 nurses (including registered, enrolled, nursing and personal care assistants) making up 50 per cent of those working in a health occupation. Medical practitioners (general and specialists) made up 10 per cent (59,500) and dental practitioners and dental associate professionals and assistants made up six per cent (35,600).

Many health occupations are experiencing shortages ■

Many health occupations are experiencing shortages. A study by the Department of Employment and Workplace Relations identified state-wide shortages of dentists, pharmacists, registered nurses, occupational therapists, speech pathologists and podiatrists. Studies by the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee identified estimated shortages of between 800 to 1300 GPs in 2002[10], and a shortfall of nurses requiring between 10,000 and 13,000 new graduate nurses in 2010.[11]

There are also issues with their distribution across the country (see Figure 14.1). The numbers of general and specialist medical practitioners, dentists and physiotherapists all decline rapidly as you move further away from major cities while nurses are evenly distributed across regions.

Figure 14.1: Nurses are the health professionals that are most evenly distributed across Australia



Source: Productivity Commission (2008), Trends in aged care services, at: http://www.pc.gov.au/research commissionresearch/aged-care-trends.

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[7] Australian Bureau of Statistics (2003), Survey of Disability, Ageing and Carers, at: http://www.abs.gov.au/ausstats/abs@.nsf/0/c258c88a7aa5a87eca2568a9001393e8?OpenDocument

[8] Carers Australia (2008), Submission 56 to the National Health and Hospitals Reform Commission.

[9] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

[10] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

[11] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

Interestingly, Australia does not currently have a shortage of health workers relative to other countries. In 2005, Australia had higher numbers of general practitioners (1.4 per 100,000) and nurses (10.9 per 100,000) relative to population compared to New Zealand (0.7 and 9.5 respectively), Canada (1.0 and 10.0), the United States of America (1.0 and 8.0), and the United Kingdom (0.7 and 9.1).[12] The rate of dentists was similar in all these countries whereas the rate of medical specialists ranged from 0.7 to 1.7 per 100,000, with Australia in the middle of that range.[13]

In the next 40 years, the proportion of people aged 65 years and over is expected to double[14] and the prevalence of complex and chronic conditions will increase. This will increase demand for health services and influence the required skill mix in future years. For example, as the population continues to age, the number of people who develop dementia is expected to increase from about 220,000 to 730,000 in 2050.[15] This will require more people trained to deliver dementia care across a variety of health care settings including general practice, hospitals and residential facilities.

It has been estimated that 'Australia may need to have over 20 per cent of the total workforce in health-related areas by 2025 if we are to maintain the delivery of services that we currently have'.[16] Moreover, the demand for informal carers will rise by 160 per cent between 2001 and 2031 compared to the supply of informal carers increasing by around 60 per cent, with the expected carer shortfall to quadruple from 150,000 to almost 600,000.[17]

Australia relies on overseas-trained health professionals, particularly in regional and remote areas where it is often difficult to recruit Australian trained professionals. 'Medicare data shows that 36 per cent of doctors currently working in Australia were trained overseas, with more than 41 per cent of doctors working in rural and remote areas having trained overseas'.[18] This is neither sustainable, nor ethical, with the World Health Organization estimating there will be a global shortage of 4.3 million health workers over the next decade to 2016.[19] Very often, the overseas-trained professionals come from countries with quite different cultures and health systems to Australia. We are often putting health professionals with the most need for support into locations where the least support is available. Further, many of these overseas-trained professionals come from countries which can least afford to lose highly trained and skilled people.

- We are often putting health professionals with the most need for support into locations where the least support is available

Australian health workforce policy should be guided by the long-term aim of ensuring that we are self sufficient on a net basis across all categories of health professionals.

While the health workforce is growing at a faster rate than other sectors (23 per cent compared to 12 per cent for all other occupations[20]), the average age of our health workers is increasing and therefore closer to retirement. In 2006[21], 16 per cent of the health workforce was aged 55 years and over, compared with 12 per cent in 2001. Our ongoing capacity to meet health care requirements, especially when considered against the prospective future workforce, will be challenged (see Figure 14.2).

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[12] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

[13] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

[14] Productivity Commission (2008), Trends in aged care services, at: http://www.pc.gov.au/research/commissionresearch/aged-care trends

[15] Productivity Commission (2008), Trends in aged care services, at: http://www.pc.gov.au/research/commissionresearch/aged-care trends

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

[17] Productivity Commission (2008),Trends in aged care services, at: http://www.pc.gov.au/research/commissionresearch/aged-care trends

[18] Australian Government Department of Health and Ageing (2008). Report on the Audit of Health Workforce in Rural and Regional Australia (Commonwealth of Australia, Canberra).

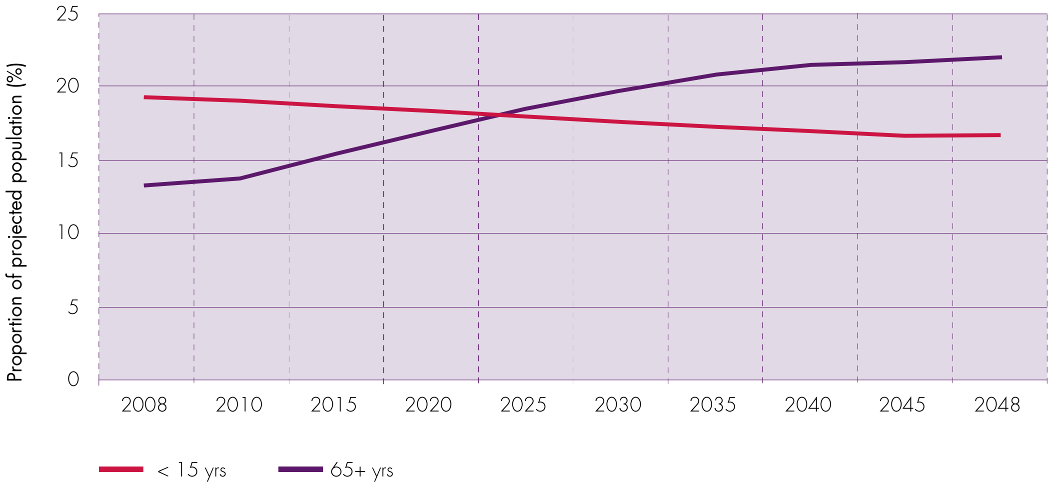
[19] Health Workforce Report 2006, World Health Organization, at: www.who.int

[20] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

[21] Australian Institute of Health and Welfare (2008), Australia's Health 2008 (Australian Institute of Health and Welfare: Canberra).

Our future total workforce is shrinking rapidly. In 2001, it was estimated that the national workforce grew by around 170,000 people per year – by 2020, this was predicted to be just 12,500 people a year.[22]

Figure 14.2: New workforce entrants will not replace those people leaving the workforce through age-related retirement



Source: Australian Bureau of Statistics (2008), Population Projections, Australia, 2006 to 2101 (Commonwealth of Australia).

So, as our need for additional entrants into the health workforce increases, our pool of people to draw from will shrink. In 2006, the ratio of health professionals to population was 29.1 per 1000 population or 593,300 people. We estimate that, in 2051, in order to maintain this ratio the proportion of the younger population (18–21) studying to be a health professional will need to increase from 16 per cent to 19 per cent. If our population health status declines or an ageing population requires an increase in the ratio of health professionals per head of population, the proportion of young people enrolled to study for health professional courses will need to increase further.

14.3 Identifying the case for change

An increasing demand for health services coupled with a diminishing labour supply poses questions about how we will meet this demand in the future.

There are limited options for how we might respond to the workforce needs of the future: improve the productivity of the existing workforce, get the existing workforce to work more hours (or delay retirement), or recruit/train more people.[23]

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[22] National Health Workforce Strategic Framework (2004), at: www.nhwt.gov.au/theframework.asp

[23] S Birch, G Kephart, G Tomblin-Murphy and colleagues (2007), Human Resources Planning and the Production of Health: A Needs-Based Analytical Framework, Canadian Public Policy, Vol XXXIII, Supplement.

14.3.1 Supporting our health workforce

Health professionals across Australia told us that they were under pressure and that this impacted on their ability to do their job, and often resulted in their leaving their health profession. This brain drain is neither productive nor efficient when considered against the investment in time and resources to educate and train people, and the lead time to recruit and train others.

> *Every nurse that leaves the profession represents a loss of public funds, and treating nurses who are rendered ill or injured from their work is a financial cost to taxpayers too. There are on-costs for the community of nurses leaving nursing, as the education of every nurse is undertaken with public dollars, and each exit from the profession is worth a loss of some $AU150,000.*[24]

Reasons given for this pressure generally related to workforce conditions including lack of respect and professional recognition, lack of professional support particularly in rural and remote regions, limited career pathways and access to ongoing professional training as well as demand pressures caused by staff shortages and the potential impact this had on patient and staff safety.

> *Many nurses now are leaving the workforce because of the lack of respect given to their profession*[25]
>
> *There are lots of rewards working in remote practice but one of the problems is that for months on end there can be no off switch and you are always on call. This isn't just about locums over holidays; it's about sharing the load for a weekend here and there or something as basic as having a night off'*[26]
>
> *Aboriginal health workers face a lot of pressure in the community. They are called on to provide support and advice by family, friends and the community at large. They are on call 24 hours a day, seven days a week.*[27]

People we spoke to overwhelmingly wanted to stay working in their chosen profession but felt that something had to give. Participants at the national consultations said:

> *We want to see a community that is proud of the health care system – that it is a profession where people want to come and work*[28]
>
> *The system has to invest in its greatest resource and that is its staff.*[29]

- People we spoke to overwhelmingly wanted to stay working in their chosen profession but felt that something had to give

One suggestion to address concerns about nurses (and other health professionals) leaving the workforce was to investigate the concept of 'Magnet' hospitals[30] (see Figure 14.3), or the 'nurse friendly facility programs' in Texas[31], or the use of Clinical Nurse Educators.[32]

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[24] Australian Nursing Federation (2008), Submission 313 to the National Health and Hospitals Reform Commission.

[25] Health professional (18 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Brisbane.

[26] Health professional (12 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Alice Springs.

[27] Participant (3 July 2008), National Health and Hospitals Reform Commission special interest forum on Indigenous health in Darwin.

[28] Participant (19 June 2008), National Health and Hospitals Reform Commission special interest forum on hospitals in Brisbane.

[29] Health professional (4 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Sydney.

[30] Australian Nursing Federation (2008), Submission 313 to the National Health and Hospitals Reform Commission.

[31] Council of Remote Area Nurses of Australia (2008), Submission 73 to the National Health and Hospitals Reform Commission.

[32] Council of Deans of Nursing and Midwifery (2008), Submission 72 to the National Health and Hospitals Reform Commission.

Figure 14.3: What is a Magnet Hospital?

The Magnet Hospital Recognition Program® evolved when an American taskforce investigating nursing workforce shortages in the 1980s found that some hospitals were able to retain and attract new staff. Developed by the American Nurses Credentialling Center, the program identifies and recognises excellence in nursing services – hospitals awarded Magnet designation are referred to as Magnet Hospitals. To achieve 'magnet' status, hospitals must be able to demonstrate 14 characteristics, known as the Forces of Magnetism: quality nursing leadership; effective organisational control; effective management style; promotional opportunities for personnel; professional models of care; quality care; quality assurance; expertise available to staff; high level of autonomy; active community outreach; positive teaching experience for nurses; positive perception of nurses; and high emphasis on personal growth and redevelopment.

The Princess Alexandria Hospital in Brisbane was granted magnet status in 2004: it reduced nursing staff turnover from 25 per cent in 1999 to just over 10 per cent two years later. A key feature of magnet hospitals is that 'they provide greater autonomy for nurses and give nurses greater control over their work' leading to improved nursing morale.

Source: F Armstrong, 'Magnet Hospitals: What's the Attraction?', Australian Nursing Journal 12 (8): 14–17.

14.3.2 Improving access in rural and remote regions

Affordable and equitable access to health care services in rural and remote areas was identified as a major issue in submissions and during the national consultations. Underpinning this were concerns about convincing health professionals to move to the bush and keeping them there, as well as identifying solutions to ensuring health care in the absence of a general practitioner.

As outlined in Chapter 9, there is a need for flexible funding arrangements that focus on multidisciplinary practice. In theory, Australians have universal access to the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). In rural and remote regions, this isn't the case, as access to the MBS and PBS is generally driven by access to a general practitioner (and in some circumstances other health professionals such as optometrists). Differential access to Medicare was raised in several submissions and in the national consultations.

> *Medicare depends on doctors being there, therefore people in rural and remote areas experience less access to care than their urban counterparts*[33]

The National Rural Health Students' Network suggests that flexible workplace models, such as outreach services need to be implemented to ensure Australians residing in such areas have equal opportunity to access the MBS and PBS.[34]

Complementing this approach, it was suggested that there is a need to extend MBS referral and PBS prescribing rights to allow all people and communities to access these services, in particular for nurse practitioners to enable them to practise to their full level of competence.[35,36]

Nurse practitioners have specific additional training and are registered and licensed within a field of competence by the relevant state nurses' registration board ■

Nurse practitioners have specific additional training and are registered and licensed within a field of competence by the relevant state nurses' registration board. While these changes have been legislated across states, no corresponding changes have been made to Commonwealth law to facilitate the practice of nurse practitioners. This prevents a nurse practitioner from writing a prescription that would be subsidised under the PBS. Similarly, diagnostic tests ordered by a nurse practitioner may not attract an MBS rebate.

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[33] Health professional (25 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Melbourne.

[34] National Rural Health Students Network (2008), Submission 522 to the National Health and Hospitals Reform Commission.

[35] Australian Nurse Practitioners Association (2008), Submission 14 to the National Health and Hospitals Reform Commission.

[36] College of Nursing (2008), Submission 66 to the National Health and Hospitals Reform Commission.

In addition to strengthening and supporting independent roles, it was also suggested that we should recognise and support supervised or 'delegated' practice. In contrast to the role of nurse practitioners, who function as independent health professionals, supervised or delegated practice involves health professionals working under negotiated delegation arrangements from another health professional, most commonly under the supervision of a medical practitioner. For example, nurses can safely perform cystoscopies.[37],[38] A delegated model would involve appropriately skilled nurses working closely with urologists and performing cystoscopies under their supervision. Under that model, the urologists would then bill for the work of the nurses they supervise.

The Productivity Commission has previously supported this approach.[39] For procedural care, there is a natural limit to provision of services. Access to billing for delegated practitioners for attendance items should possibly be regulated more tightly to specific classes of practitioners, such as physician assistants.

Other strategies raised in submissions and consultations for improving access to health services for people living in rural and remote areas included expansion of specialist outreach services, telehealth, and referral and advice networks. These are discussed in Chapter 9.

14.3.3 Strengthening education and training

The siloed education and training of nurses, allied health professionals and doctors was identified as a major cause of service fragmentation in the national consultations and through the submissions received:

> *… the education of health students needs to be in a common and more integrated educational environment. Integrated and common education in health allows for easier cross-discipline movement and the ability for graduates to be more flexible and mobile in their practice.*[40]
>
> *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.*[41]

- The siloed education and training of nurses, allied health professionals and doctors was identified as a major cause of service fragmentation

Universities are increasingly moving to single generalist degrees with further education offered in areas of speciality. For example, the University of Melbourne has moved all of its initial health professional education to graduate entry. Other universities are also increasing the range of programs which provide initial professional education as graduate entry programs. Students then specialise by undertaking postgraduate studies in areas such as medicine.

Clinical training and placements were also raised as issues. The uncertainty around the availability of places and the consistency of placements from one provider to the next was seen as an impediment to producing high quality graduates. One forum participant captured the sentiment of many participants:

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[37] S Radhakrishnan and colleagues (2006), 'Nurse-led flexible cystoscopy: experience from one UK centre'. British Journal of Urology International 98 (2): 256–8.

[38] J de Bie and colleagues (2004), 'Reserved procedures in Dutch hospitals: knowledge, experiences and views of physicians and nurses', Health Policy 68(3): 373–84.

[39] Productivity Commission (2005), Australia's Health Workforce.

[40] Australasian Council of Paramedicine (2008), Submission 28 to the National Health and Hospitals Reform Commission.

[41] Australian Nursing Federation (2008), Submission 313 to the National Health and Hospitals Reform Commission.

> *The current health worker students are the future of the health and medical workforce and unless we invest in them, both through funding adequate clinical training capacity as well as quality and clinical training, then the health system will continue to suffer*[42]

At present the health sector is not accountable for the quality of clinical placements and the level of supervision. Conversely, universities and vocational education and training providers are not accountable to the health sector for the quality of the preparation students receive prior to clinical placements and the total number of clinical placement hours a student might receive.

We need to embrace all available training sites and create a culture where teaching and learning are considered 'core business' of our health system ■

In order to train the future workforce, we need to embrace all available training sites and create a culture where teaching and learning are considered 'core business' of our health system. At the moment this is not possible because of the lack of infrastructure and ongoing educational support outside of the traditional hospital setting, and to a lesser extent community setting (for example, general practice and community health centres). Participation by professionals in educating the next generation takes time and needs to be recognised and funded appropriately. This sentiment is echoed by the Australian Medical Students Association:

> *Past experience has shown that you cannot simply turn the tap on or off when it comes to medical workforce. It takes a long time to train a medical practitioner and it is not possible to conjure up new resources such as supervisors, rooms, facilities, new operating theatres etc overnight. It takes time to put all of the supports in place to ensure that a medical practitioner gets the level of training and education that they need…Australia faces the real prospect of a training emergency … The clock is clearly ticking and to that extent, above all else, our message to the Commission is that this issue needs to be tackled as a matter of urgency.*[43]

The only 'new' educational infrastructure that has been established in the last 10 years has been the Rural Clinical Schools (see Figure 14.4). Rural clinical schools have been successful in creating new educational opportunities that have begun to address the regional, rural and remote workforce gaps. Anecdotally, we were told that 75 per cent of rural students and 50 per cent of metropolitan students studying at Charles Sturt University in Dubbo remained in the area once they finished their training.[44]

We believe that this model of infrastructure and long-term educational support could be extended to urban and semi-urban environments, linked to universities and the vocational sector and across a broad range of professions.

Figure 14.4: Rural Clinical Schools are encouraging more graduates to work in rural and remote centres

The Rural Clinical Schools program has been operating since 2000. They are designed to encourage medical students to take up a career in rural practice by enabling them to undertake extended clinical training placements in rural locations. The program is also designed to encourage professionals to take on rural academic positions – this is often undertaken with local health services.

There are now 14 Rural Clinical Schools across Australia, managed by 13 universities. These schools are required to provide 25 per cent of Australian Government supported medical students a minimum of one year of their clinical training in rural areas by the time they graduate.

The Rural Clinical Schools Program's annual placements increased from approximately 380 in the 2006 calendar year to 467 in 2007, reflecting the expansion of existing schools, and the three new schools that joined the program in 2006–07: the Australian National University, James Cook University and the University of Newcastle.

Source: Department of Health and Ageing www.health.gov.au and Department of Health and Ageing Annual Report 2007–2008

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[42] Health professional (18 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Brisbane.

[43] Australian Medical Students Association (2008), Submission 503 to the National Health and Hospitals Reform Commission.

[44] Health professional (3 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Dubbo.

14.3.4 Building and planning for a flexible workforce

By 2020, it is a fair assumption that technology advances will mean 'different models of care and new workforce practices will be required to accommodate the wider range of treatment possibilities'.[45] Already, in the last 10 years we have seen rapid advances in the treatment of heart disease with a shift in surgery from coronary artery bypass grafting to percutaneous coronary intervention with angioplasty. This has required significant change in work practice and skill mix. The changing burden of disease and an ageing workforce will also impact on the skill mix required.

Tied in with this concept is the need to make better use of our existing workforce to address workforce shortages (or uneven distribution) of health professionals, to improve access to health services and to continue to provide high quality health care.

Strategies to meet these concerns included extending the role of existing professionals (for example, reporting on X-rays might be undertaken by a medical imaging technologist) and creating new types of health workers (for example, physician assistants, hospitalists). The Queensland Government is undertaking a 12-month pilot program to employ physician assistants as one way to 'help us improve health care delivery in the face of a worldwide shortage of doctors'.[46] Using information technology more effectively to improve efficiency and placing more emphasis on prevention and health promotion[47], as well as extending national registration[48,49] have also been suggested.

The national consultations and submissions also suggested planning for a multi-skilled team-based workforce[50] with an emphasis on matching skills to patient needs and the complexity of health care required. Submissions provided the following comments:

> *… we've got lots of turf wars and what we would like to see is a focus on what the actual patient needs or client needs are, the community needs along different care pathways or from wellness through sickness and from being able to die well. And then what are those care needs and then let's design the health workforce around that instead of turf. So we could have a lot of new roles such as paramedic practitioners in the community. It's ridiculous that a paramedic practitioner, a paramedic in the community, can't catheterise a patient and they bring him into hospital for that.*[51]
>
> *A controlled trial in Victoria has demonstrated that experienced, well qualified physiotherapists can competently and safely undertake screening of patients referred to public hospital orthopaedic outpatient clinics with non-urgent musculoskeletal pain. In that study nearly two-thirds of patients with non-urgent musculoskeletal conditions referred by their GPs to one public outpatient orthopaedic department did not need to see a surgeon at the time of referral, and were appropriately assessed and managed by experienced, qualified physiotherapists.*[52]

There was recognition that in some regions, health professionals need to be better skilled or supported to treat a wider range of conditions, particularly in the absence of a general practitioner. Suggestions[53] included enhancing the use of nurse practitioners, training and up-skilling Aboriginal

■ In some regions, health professionals need to be better skilled or supported to treat a wider range of conditions

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[45] Productivity Commission (2005), Australia's Health Workforce, Research Report, Canberra.

[46] Minister for Health, The Honourable Stephen Robertson, Media Release, Physician's Assistant Trial Sites Announced, Saturday 16 August 2008.

[47] Australian Health Workforce Institute (2008), Submission 37 to the National Health and Hospitals Reform Commission.

[48] Australian Nurse Practitioners Association (2008), Submission 14 to the National Health and Hospitals Reform Commission. College of Nursing (2008), Submission 66 to the National Health and Hospitals Reform Commission.

[49] Royal College of Pathologists of Australasia, Pathology Associations Committee (2008), Submission 161 to the National Health and Hospitals Reform Commission.

[50] Health professionals (June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Sydney, Darwin, Perth and Canberra.

[51] Health professional (28 May 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Hobart.

[52] Australian Physiotherapy Association (2008), Submission 41 to the National Health and Hospitals Reform Commission.

[53] Health professionals (June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Brisbane, Dubbo, Sydney, Cairns, Shepparton, Geraldton and Canberra.

health workers, using paramedics to suture or unblock catheters, using dental hygienists to clean teeth to free up dentists to do complex treatment and procedures, and using nurses to triage patients. One submission suggested that:

> *The expanded use of non-medical health professionals, such as nursing assistants, paramedics and allied health practitioners, in remote locations may enable the delivery of a wider range of low-risk health services. Such non-medical care providers may be able to improve access to a limited range of interventions based on standardised practice guidelines and protocols, including minor illness and injury care, patient education and chronic condition monitoring.*[54]

There are enormous possibilities.

It is important that we have a structure that will facilitate the building of a workforce that will be flexible to meet changing workforce practices and workforce shortages. A suitable framework would allow for skills development and up-skilling in the shortest possible timeframe without compromising safety and quality but ensuring a workforce competent to meet the needs of all Australians including Aboriginal and Torres Strait Islander people, people with intellectual disabilities and people from non-English speaking backgrounds. At the same time, we need a workforce planning model that, in addition to identifying areas of workforce shortage, incorporates identification of pipeline technologies that will impact on future skill mix.

Equally important is the need to manage these functions. Catholic Health Australia proposes the establishment of a National Health Workforce Commission to plan and manage the range of health workforce issues including planning, regulation, training, accreditation and registration, as well as reviewing the roles and boundaries of current professional occupations with a view to increasing flexibility and expanding the scope of practice to better reflect the skills and competencies of those professionals.[55]

14.3.5 Increasing the number of Aboriginal and Torres Strait Islander peoples in the health workforce

Aboriginal and Torres Strait Islander people are under-represented in the health professions ■

Aboriginal and Torres Strait Islander people are under-represented in the health professions. While 2.3 per cent of the Australian population is Aboriginal or Torres Strait Islander, only 1.6 per cent of the national health workforce is made up of Aboriginal and Torres Strait Islander people.[56] The under-representation is magnified when you consider that Aboriginal and Torres Strait Islander people account for 95.5 per cent of Aboriginal health workers, but they only represent 0.2 per cent or less of all other health professions.[57]

In 2001, there were 90 Aboriginal and Torres Strait Islander medical practitioners (see Figure 14.5). This is 90 per cent (928) less than the 1,018 that would be representative of the Aboriginal and Torres Strait Islander population. In 2001, there were fewer than 800 Aboriginal or Torres Strait Islander nurses, more than 2500 short of the pro rata expectation (see Figure 14.5).

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[54] Defence Health Services Division (2008), Submission 76 to the National Health and Hospitals Reform Commission.

[55] Catholic Health Australia (2008), Submission 57 to the National Health and Hospitals Reform Commission.

[56] Pathways into the health workforce for Aboriginal and Torres Strait Islander people: A blueprint for action (Commonwealth of Australia 2008).

[57] Pathways into the health workforce for Aboriginal and Torres Strait Islander people: A blueprint for action (Commonwealth of Australia 2008).

Figure 14.5: We need to train more Aboriginal and Torres Strait Islander health professionals

Health occupation	Number in 2001	Pro rata	Gap
GP/medical specialist	*90*	*1018*	*928*
Medical imaging	*14*	*163*	*149*
Dentist	*13*	*174*	*16*
Registered nurse	*789*	*3359*	*2570*
Retail pharmacist	*10*	*285*	*275*
Occupational therapist	*7*	*126*	*11*
Optometrist	*5*	*64*	*59*
Physiotherapist	*29*	*242*	*213*

Source: A report by Access Economics for the Australian Medical Association, 2004, 'Indigenous Health Workforce Needs'

It is important to 'maximise Aboriginal and Torres Strait Islander participation in the health workforce'[58] including as doctors, nurses, dentists and specialists to improve health outcomes of and reduce the life expectancy gap for Aboriginal and Torres Strait Islander peoples.[59]

Aboriginal health workers are highly valued for the work that they do.

> *Aboriginal health workers are so important because a blackfella will go to a blackfella when they won't go to a whitefella.*[60]

We were told that barriers to the education and training of an Aboriginal and Torres Strait Islander health workforce were: lack of role models; having to leave families and communities to undertake training; the lack of recognition of prior learning; the lack of support both financial and academic; and undefined pathways to higher education. Participants in the national consultations emphasised:

> *We need to investigate why Indigenous people are not getting involved in the health workforce. There is currently a culture where Indigenous people are not motivated to consider a career in health or feel that 'they can ('t?) do it.' All Indigenous young people hear are the disaster stories – you'll be sicker, you have a lower life expectation.' These messages directly impact on their aspirations for life and the future.*[61]
>
> *When Indigenous children are asked what they want to do, it is hardly ever a health career. The only time Indigenous children think about entering a health profession is when they have role models, such as a family member, working in the health field. If they do not have role models, children are not properly informed of career choices and are less likely to think of working in the health sector.*[62]

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[58] Pathways into the health workforce for Aboriginal and Torres Strait Islander people: A blueprint for action (Commonwealth of Australia 2008).

[59] Australian Indigenous Doctors' Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

[60] Health professional (8 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Geraldton.

[61] Participant (26 June 2008), National Health and Hospitals Reform Commission special interest forum on Indigenous health in Melbourne.

[62] Participant (26 June 2008), National Health and Hospitals Reform Commission special interest forum on Indigenous health in Melbourne.

The Australian Health Workforce Institute informed us that most Aboriginal and Torres Strait Islander students study health-related courses at James Cook University, the University of Newcastle, the University of Western Australia and UNSW because these universities have committed resources to programs that include outreach into high schools, bridging programs and dedicated student support. They also argued that there is a need to ensure that the responsibility for educating Indigenous doctors is spread more evenly and not left to a small number of medical schools.[63]

The recently released report, *A Blueprint for Action: Pathways into the health workforce for Aboriginal and Torres Strait Islander people*, also identified the need to improve the education outcomes of Aboriginal and Torres Strait Islander students in primary as well as secondary schools. This report provides a well argued comprehensive set of recommendations to redress the shortages of Aboriginal and Torres Strait Islander people in the health professions. We believe that this report and its recommendations could be used to guide planning for future Aboriginal and Torres Strait Islander workforce needs.

14.3.6 Building a health workforce for Aboriginal and Torres Strait Islander people

As outlined in Chapter 8, there are several barriers to Aboriginal and Torres Strait Islander people accessing health care including inadequate training for health professionals to deal with cross-cultural issues, complex multiple morbidities and issues specific to Aboriginal and Torres Strait Islander health. The Australian Indigenous Doctors Association emphasised that

> *Australia must strive for a medical system which will equip all graduates with the necessary knowledge, skills, attributes and cultural understanding to competently practice in Australia.*[64]

This is also the intent of the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework which was endorsed by the Australian Health Ministers Advisory Council in 2002.

People across Australia emphasised the importance of cultural sensitivity and respect in gaining the confidence of Aboriginal and Torres Strait Islander people to access health services. We heard that:

> *Aboriginal and Torres Strait Islander people are more likely to access, and will experience better health outcomes from, services that are respectful and culturally safe places for Aboriginal and Torres Strait Islander people.*[65]

All people need to receive high quality clinical care that respects their cultural backgrounds ■

The need for clinical and cultural competence is not restricted to Aboriginal and Torres Strait Islander people. All people need to receive high quality clinical care that respects their cultural backgrounds.

Our reform directions proposed in Chapter 8 (including the proposed National Aboriginal and Torres Strait Islander Health Authority and strengthened accreditation processes) will contribute to building a clinically and culturally competent workforce, as will increasing the number of Aboriginal and Torres Strait Islander people across the health professions.

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[63] Australian Health Workforce Institute (2008), Submission 37 to the National Health and Hospitals Reform Commission.

[64] Australian Indigenous Doctors' Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

[65] Australian Indigenous Doctors' Association (2008), Submission 467 to the National Health and Hospitals Reform Commission.

14.4 Creating a better future

Our reform directions are aimed at providing the building blocks to enable the current and existing workforce to be more productive and efficient and to ensure patient safety and quality of services are not compromised.

We want the workforce of the future to be a dynamic team, comprising individuals who are highly qualified, adaptable and technically competent. Strong leadership will make sure that the right care is provided at the right time, in the right place by the right person. These teams will be shaped by the need to work 'smarter', advances in technology, and community expectations, and will be facilitated by a multidisciplinary, rather than a solitary, approach to care.

Our first reform direction relates to our current workforce. We believe that the Australian health system has an outstanding group of health professionals who are under stress and need to be supported.

Reform direction 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.
- 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).

We believe that supporting people in the workplace will maintain and increase participation rates. This is an important step in making sure we keep and attract as many people as possible to the health professions and workplaces. Keeping good, experienced staff in the system is more efficient than relying on a production line of new, junior staff. We need to show our current staff they are valued, particularly through strengthening morale and improving culture. This will require good leadership throughout the system and listening to and valuing the opinions of staff.

■ Keeping good, experienced staff in the system is more efficient than relying on a production line of new, junior staff

We would welcome feedback on mechanisms to improve workforce culture, management and leadership.

Clinical Senates currently operate in Western Australia[66] and South Australia 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'.[67] In South Australia, the Clinical Senate has been instrumental in informing the developments around the new model of clinical care for the newly planned tertiary hospital, the creation of state-wide clinical networks, the establishment of new clinical research fellowships and innovations in workforce models (e.g. physician assistants) and education. A Clinical Senate is also to be established in Queensland.

Some states have used other processes to involve clinicians in health planning. In 2000, NSW Health established a Clinical Council, supported by a series of Clinical Implementation Groups, to involve clinicians more actively in setting and monitoring clinical policy. Clinicians were strongly involved in implementing the Government Action Plan, arising from the 2000 Menadue report. The model used by NSW was to establish specialty or service-specific working groups, co-chaired by a leading clinician and a senior bureaucrat, to review the strategic directions for particular services. This evolved subsequently into the Greater Metropolitan Clinical Taskforce.[68]

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[66] See, for example, information on the Western Australian Clinical Senate, at: http://www.clinicalsenate.health.wa.gov.au/home/

[67] www.health.sa.gov.au

[68] Information on the Greater Metropolitan Clinical Taskforce is at: http://www.health.nsw.gov.au/gmct/index.asp

Our second reform direction addresses issues of productivity and improves access to health care in geographic locations that do not always have access to a doctor. We believe it is important to ensure equity of access across the country, and that in the absence of a doctor we need to maximise the use of health professionals to the level of their competency.

The proposed strategies recognise that nurses are relatively evenly distributed across Australia but other professions are not. We need to use the nurses in areas of workforce shortage to the maximum level of their competence, and to enhance the productivity of the other professions who are practicing in areas of workforce shortage.

Reform direction 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.

Third, we believe a new education framework will facilitate the development of high functioning, multidisciplinary teams to make more efficient use of the health workforce. There are several inter-related components to this framework, including dedicated funding for clinical placements and establishing a new training infrastructure. It is crucial that the health system needs to revalue and support the education of our future health workforce and we are concerned that with the ever increasing service needs, education will be ignored. This funding should follow the students.

Reform direction 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).

We believe a competency-based framework will enhance the effective use of all professional groups and individuals in ways that maximise the use of skills without compromising patient safety and quality of services. Competencies are what a person needs to do, and to know, to carry out a particular job role or function. For example, competency-based training for wound care is designed to suit the nurse or health care worker who is caring for those at risk of developing wounds or currently have a wound that is slow to heal and includes topics such as tissue identification, different wound care products and bandaging.

We expect that a competency framework would allow for a wide variety of entry points into health care careers, recognise prior learning and would foster more flexible, multidisciplinary training across all undergraduate programs.

The idea of a competency framework is not new. In Australia, the National Health Workforce Taskforce's work program includes examining the feasibility of a core competency framework for all health professions, as well as the development of core competencies for acute and aged care, and maternity services. Further, the Community Services and Health Industry Skills Council are well advanced in the development and implementation of core competency-based modules for health care workers' education in the vocational education and training sector. Internationally, the United Kingdom has implemented workforce reforms underpinned by a competency framework, commonly referred to as the 'Skills Escalator' (see Figure 14.6).

Figure 14.6: The United Kingdom Skills Escalator

The Skills Escalator is a nine-level career framework introduced by the National Health Service in Britain. It provides multiple entry points into health care careers and staff are encouraged through a strategy of lifelong learning to constantly renew and extend their skills and knowledge, enabling them to move up the escalator. Staff may wish to develop their skills at a particular level of responsibility. Others may choose to develop the skills necessary for the next level of responsibility.

A Career Framework for the NHS

NHS
Institute for Innovation
and Improvement

More Senior Staff	9
Consultant Practitioners	8
Advanced Practitioners	7
Senior Practitioners/Specialist Practitioners	6
Practitioners	5
Assistant Practitioners/Associate Practitioners	4
Senior Healthcare Assistants/Technicians	3
Support Workers	2
Initial Entry Level Jobs	1

Source: Presentation by B Crump, NHS Institute for Innovation and 'Introduction to the Skills Escalator'. At: www.dh.gov.uk

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Clinical training for health professionals should be embedded in all undergraduate and postgraduate courses, and be provided in both public and private hospital and community settings to foster quality educational experiences and bridge the current siloed model of training.

Our fourth reform direction brings together the component parts necessary to build and plan for a flexible workforce.

Reform direction 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.

The establishment of a National Clinical Education and Training Agency would improve accountability and transparency of the education and training of health professionals. A key role of this agency would be national workforce planning to identify future skill needs to assist in the allocation of education and training funding. We expect that this work would include the consideration of potential labour-saving technologies (for example, digital/computer radiology) on skill mix, and therefore planning. This function could be outsourced to the Australia and New Zealand Horizon Scanning Network.

Another key role of this agency is to identify and facilitate the up-skilling of health professionals in areas of workforce shortage to ensure that Australians living outside major cities have their health needs met. Efficiencies can be gained if a national approach is taken.

This agency would also be responsible for identifying gaps in specialist medical training. Available data[69] suggests that for some specialities it is difficult to obtain a clinical placement. In 2007, there were 56 applicants for a first-year basic training placement in dermatology but only 30 per cent (17) were successful in achieving a place. Also in 2007, there were 189 applicants for a first-year advance training placement in obstetrics and gynaecology but only 32 per cent (61) were successful in achieving a place.

We expect this agency would have mechanisms to involve representatives from the state, territory and Commonwealth departments responsible for health and education, the university and vocational education and training sector, the private health sector, and other appropriate professional organisations.

We note the National Health Workforce Taskforce is doing work in this area, but there is a need to formalise, continue and expand its work.

Our fifth reform direction builds on the current Council of Australian Governments (COAG) work on national registration for health professionals. We were consistently told during our consultations that the fact that each health professional in moving across state boundaries had to reapply for registration was inefficient and illogical. This impediment would be removed by national registration. We believe that national registration will allow for improved workforce planning which at the moment is disjointed and uncoordinated.

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[69] Medical Training Review Panel, Eleventh Report, December 2007 (Commonwealth of Australia 2008).

Reform direction 14.5

We support national registration to benefit the delivery of health care across Australia.

Next, we believe that a comprehensive national strategy to recruit, retain and train Aboriginal and Torres Strait Islander health professions is needed. This reform direction is consistent with the strategic directions outlined in *A Blueprint for Action*.

Reform direction 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.

As outlined in Chapter 9, building a quality workforce in rural and remote Australia is a complex challenge and requires sophisticated strategies of recruitment and support from undergraduate through to specialist training and continuing professional development across all disciplines, including medicine, oral health, nursing and other allied health groups. In addition to the reform directions mentioned above, we believe there is a need to train people locally so they either stay or return.

Reform direction 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.

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15. Fostering continuous learning in our health system

Key messages

- Australia has an excellent tradition and track record of achievement in health and medical research. This is arguably our nation's strongest area of research.
- Research is often not considered part of the core business of operating health services and/or is squeezed out by immediate service demands, resulting in a lack of alignment and integration of research into clinical practice.
- In particular, research focused on the way health services improve health outcomes – health services research – is under-resourced; it constitutes less than three per cent of the budget of the National Health and Medical Research Council (NHMRC), the Commonwealth Government's principal health and medical research funding body.
- The biggest failure in health care is to implement what we know already. We need better means of translating research findings into a 'system' of clinical practice in a timely way.
- We need to redesign the health system to encourage and reward 'good' care (for example, via knowledge-based protocols), while continuously learning from 'bad' care (for example, medical incidents, adverse events, complaints).
- Comparative information on outcomes of health care processes is critical to improving the safety and quality of health care.
- Effective communication between a patient's multiple health care professionals, and a relationship of cooperation and trust, are equally important to ensuring a safe outcome and a positive patient experience.
- Strengthened clinical and managerial leadership, governance and resourcing across the health and aged care system is required to promote and embed a culture of safe, high quality and effective health care.

Our reform directions

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.

15.1 Defining and scoping a continuous learning system

Every Australian has a vested interest in the safety and quality of health services. That interest is intensified as we, or our family and friends, require help with a health problem. However, there is no easy way for us to be sure that the care we receive will be based on the current best evidence combined with individual clinical expertise, which is then judiciously applied to our personal circumstances.

- Every Australian has a vested interest in the safety and quality of health services

The quantum increase in the capacity of health consumers and professionals to access the rapidly growing array of health and medical information available on the World Wide Web and elsewhere is both a boon and a risk. It has dramatically increased knowledge about potential conditions and treatments but it has also created uncertainty. How can clinicians possibly manage to absorb and utilise the swathes of rapidly emerging evidence in their day to day practice? As consumers of health care services, how do we know whether to put trust in our health care practitioner, or the latest advice from a self-help book, the internet or the latest medical television drama?

There is no easy way to find our way through this avalanche of information, but there are certain characteristics of health care systems which can reassure health care consumers that they are receiving the right care, at the right time, delivered by the right person, in the right setting.

First, we need to be assured that sufficient resources are being applied to areas of health and medical research to promote:

- health and wellbeing, and prevent ill health;
- delivery of more effective health care based on evidence of what works; and
- development of new therapies and cures.[1]

Without research, health care would not improve. Research is therefore an enabler of progress, which needs to be recognised, valued and integrated with the health system.

Next, the health system must be ready and capable of applying emerging research findings into clinical practice. Currently it may take lengthy periods – typically, an astonishing 17 years[2] – for evidence to be incorporated into practice. To hasten implementation of evidence-based practice, health services require strong clinical leadership, easy access to guidance which incorporates contemporary knowledge, a system of checks and balances, and a workplace culture which values and rewards innovation and clinical excellence.

Finally, information is critical to all participants in the healthcare system – consumers, clinicians, managers, policymakers and planners. Without the capacity to measure the time taken to receive care, the outcome of care processes, the patient's experience of care, or to evaluate variation or deviation from a norm or a target, we cannot continuously learn and improve the care we deliver.

Between 15 and 20 per cent of hospital overnight episodes result in an adverse event. Such events and mistakes potentially cost the Australian health system a cautious estimate of $2 billion a year.[3] This estimate does not even consider the potential waste of resources involved in repeated testing, providing unnecessary care, or undertaking interventions which have no evidence base or deviate from best practice.

A concentrated effort to minimise harm and to 'systematise' evidence-based care will have a positive impact on community trust as well as the efficiency and effectiveness of our health system.

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[1] National Health and Medical Research Council (2007), Strategic Plan, 2007–2009, at: http://www.nhmrc.gov.au/publications/synopses/nh80syn.htm

[2] Australian Commission on Safety and Quality in Health Care (2008), Submission 428 to the National Health and Hospitals Reform Commission.

[3] J Ehsani, J Jackson and colleagues (2006), 'The incidence and cost of adverse events in Victorian hospitals 2003–04', Medical Journal of Australia 184 (11): 551–555.

15.2 Building on our strengths

15.2.1 The strengths of Australia's research effort

Australia has an excellent tradition in health and medical research, which is one of the nation's strongest areas of research

Australia has an excellent tradition in health and medical research, which is one of the nation's strongest areas of research. Several Australians have won Nobel Prizes for their medical research – most recently Barry Marshall and Robin Warren in 2005 for their work on the bacterium *Helicobacter pylori*, and Peter Doherty in 1996 for his work on how the immune system recognises virus-infected cells. Another key indicator of Australia's success in this area is performance against the international benchmark of citation. This relates to how often research academics refer to each other's formal published work. Australia greatly exceeds the expected number of citations.[4]

Health and medical research is performed in all parts of the health system – by the public, private, and not-for-profit sectors. Many different organisations are involved, including universities, hospitals, medical research institutes, primary health care and community-based organisations, government agencies and private firms. Funding comes from a variety of sources – from all levels of government, local and international firms and the philanthropic sector. The Commonwealth Government is the largest funder – in 2005–06, providing 67 per cent (or two-thirds) of recurrent funding, with the private sector and state and local governments respectively providing 21 per cent and 12 per cent (see Figure 15.1).

Figure 15.1: The Commonwealth Government provides about two-thirds of research funding and its funding is growing rapidly

Source	2003–04 ($ million)	2004–05 ($ million)	2005–06 ($ million)
Australian Government	*1023*	*1133 (up 10.8%)*	*1221 (up 7.8%)*
State/local governments	*180*	*208 (up 15.5%)*	*219 (up 5.2%)*
Non-government/private sector	*340*	*374 (up 10%)*	*394 (up 5.3%)*
Total	*1543*	*1715 (up 11.1%)*	*1834 (up 6.9%)*

Source: Australian Institute of Health and Welfare (2007), Health Expenditure Australia 2005–06 (Australian Institute of Health and Welfare: Canberra)

The Commonwealth Government funds health and medical research in two primary ways: through direct grants by two funding bodies and through indirect support. The bulk of the direct health and medical research funding is administered by the National Health and Medical Research Council (NHMRC), which is part of the Commonwealth Health and Ageing portfolio of agencies. The NHMRC seeks to fund the best and most relevant research to improve the health of all Australians, and to influence and support the translation of research outcomes, here and internationally, into improved health and health care practices.[5] The Australian Research Council (ARC) also administers Commonwealth Government funding. The NHMRC is specifically focused on health and medical research and the ARC is responsible for supporting research in the sciences and humanities. The ARC explicitly does not fund some kinds of health research, principally in clinical medicine and dentistry. Both organisations sponsor research through grants. Funding is awarded on a competitive basis, through peer review of proposals.

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[4] P Bourke and L Butler (1997), 'Mapping Australia's basic research in the medical and health sciences', Medical Journal of Australia (167): 610–613.

[5] National Health and Medical Research Council (2007), Strategic Plan, 2007–2009, at: http://www.nhmrc.gov.au/publications/synopses/nh80syn.htm

The Commonwealth Government also supports research through 'infrastructure' grants to universities and medical research institutes and through its support for the salaries of academic staff in universities who conduct research alongside their teaching duties.

The benefits of research greatly exceed the costs. A recent study by Access Economics stated that:

> *Australian health research and development expenditure between 1992–93 and 2004–05 is estimated to return a net benefit of approximately $29.5 billion. For the average dollar invested in Australian health research and development, $2.17 in health benefits is returned, with a minimum of $0.57 and a maximum of $6.01.* [6]

15.2.2 The strengths of Australia's efforts to improve the quality and safety of health care

The safety and quality 'movement' in health care is relatively new but has gained momentum over the last two decades from[7]:

- research illustrating the large volume of potentially preventable harm occurring in hospitals;
- high profile public inquiries where health systems were revealed as unsafe that increased the awareness of the public, professions and government; and
- the idea that medicine should be evidence based and the knowledge that it frequently was not.

Action has been called for by many sources. Particularly influential were the reports published in the United States by the Institute of Medicine (IOM), especially *To Err is Human*.[8] Similarly, in Australia a landmark study, the *Australian Quality in Healthcare Study*, revealed that 17 per cent of all hospital admissions were associated with adverse events, the majority considered preventable.[9]

One of the major policy responses to this in Australia was the formation, in 2000, of the Australian Council on Safety and Quality in Health Care, the predecessor body to the current Australian Commission for Safety and Quality in Health Care.

During this period, there has been a shift in both the awareness of, and investment in, safety and quality throughout Australia. It is now regularly reviewed at executive levels and is a component of many service and performance agreements. This has been supported by investment in units of staff dedicated to safety and quality and bodies such as the Australian Commission for Safety and Quality in Health Care, the National Institute of Clinical Studies, similar state based bodies as well as complaints commissions. These bodies have developed and implemented: policy; educational materials; and processes and measures for improvement (e.g. credentialing, open disclosure, patients' rights, standardising charting, mortality reviews, incident monitoring, and root cause analysis teams). These reforms over the last decade have made significant headway in improving the safety and quality of health care for patients.

■ Australia's credible international ranking on a range of measures of health care performance shows that the Australian health system isn't 'broken'

Australia's credible international ranking on a range of measures of health care performance show that the Australian health system isn't 'broken'. However, national and international evidence suggests that many patients still don't receive all care that is recommended, and preventable

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[6] Access Economics (2008), Exceptional returns: the value of investing in health R&D in Australia II, at: http://www.asmr.org.au/ExceptII08.pdf

[7] Australian Commission on Safety and Quality in Health Care (2008), Submission 428 to the National Health and Hospitals Reform Commission.

[8] Institute of Medicine (1999), To err is human: building a safer health system, at: http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf

[9] W Runciman, R Gibberd and colleagues (1995), 'The quality in Australian health care study', Medical Journal of Australia (163): 458–471.

adverse events continue to occur.[10] While there are no firm measures of either the extent of the problem or the baseline from which we are working to improve, it is likely that the work that has been done to improve quality and safety has helped the health system meet increasing demands over the last 10 years.

However, despite significant investment in Australia, the reach of change into the practices of clinicians has been variable, and many initiatives have not proved sustainable. Difficulties in measuring the effect of improvement efforts have frustrated attempts to clearly identify strategies that 'make a difference'. This means that patients and their families may be uncertain as to whether they can rely on care to be safe or even effective. Nonetheless, in Australia there are now networks of individuals who understand the issues, who are motivated to implement improvement and generally willing to implement reforms. The potential for implementing change in this environment is high.

15.3 Identifying the case for change

15.3.1 Valuing research as core business

While the health and medical research culture and clinical culture can be understood as different things, the two co-exist in the health system. However, the way that research is organised and funded in the context of all health services, public and private, does not readily encourage or reward health service providers for engaging in research, or for adapting the way they deliver health care in line with research outcomes. This situation exists because research is often not considered part of the core business of operating health services. In the context of significant day-to-day pressures on public hospitals, research tends to be treated as a supporting activity, disconnected from, and a lower priority than, patient care. As a consequence there has been little attention given to the potential offered by a closer alignment of research with clinical practice along with the mechanisms and support systems required to promote integration.

This concern was raised in many submissions. A number of research bodies are concerned about the demise of the research culture within Australia's major public hospitals:

> *The research culture in our major hospitals has been severely eroded by health care agreements that are focussed almost exclusively on short-term outcomes and numbers of clinical transactions. There is no recognition, measurement or reward for research activities … and clinician time is only valued if it is directed to clinical service delivery.*[11]
>
> *A worrying trend is that for some public hospitals, teaching and research are now seen as somewhat discretionary.*[12]

The limited recognition and separate treatment of research in the health system has real, although not immediately obvious, consequences. First, it means that many opportunities to perform meaningful research that can improve clinical practices and standards are lost. Second, there is a lack of connection, or knowledge transfer, between research and clinical practice. This means that there is not optimal use of the available knowledge to improve standards of health care and make the most efficient and effective use of health expenditures. Third, the drive to develop the high quality researchers that will be our future clinical research leaders is not supported.[13] Fourth, there are no incentives to build collaborative partnerships across health services (hospital and community), universities and research institutes. There is constant competition among research organisations for limited resources that leads to inefficiencies and wasted opportunities for improving the health of our communities.

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[10] Australian Commission on Safety and Quality in Health Care (2008), Windows into safety and quality in health care (Australian Commission on Safety and Quality in Health Care: Sydney).

[11] Walter and Eliza Hall Institute of Medical Research (2008), Submission 192 to the National Health and Hospitals Reform Commission.

[12] Universities Australia (2008), Submission 461 to the National Health and Hospitals Reform Commission.

[13] T Cutler (2008), Report on the review of the national innovation system: Venturous Australia – building strength in innovation, at: http://www.innovation.gov.au/innovationreview/Documents/NIS-review-web.pdf

In the United Kingdom, the government has recently reinvigorated the research culture within the National Health System with the establishment of the National Institute of Health Research in 2004 and with the specific agenda of strengthening the interaction between research and clinical practice. A more recent review under Lord Darzi has reaffirmed this important strategic direction.[14]

Our health system is under pressure and in need of reform to meet long-term challenges related to unequal access to services, the growing burden of chronic disease and an ageing population. We believe that meeting these challenges requires that we change the culture of the health system so that research and knowledge transfer are recognised as essential prerequisites to improving patient outcomes.

- Meeting thesechallenges requires that we change the culture of the health system so that research and knowledge transfer are recognised as essential prerequisites to improving patient outcomes

15.3.2 A piecemeal approach to safety and quality

The overwhelming view expressed about improving the quality and safety of health care was that there is a growing understanding of what needs to be done and enormously good intentions to do it. Despite this, there are too many barriers and frustrations to achieve more than marginal, piecemeal improvement. Is it the safety of care provided which is paramount or is it more about caring enough to continuously improve the quality of care we provide? How do we do this when many staff feel there are too few staff, too little time and too many patients to manage safely with personalised care? Is a top-down approach to quality involving credentialing, accreditation and performance benchmarking more important, or the capacity to innovate locally and share results nationally?

The Australian Commission on Safety and Quality in Health Care recommends the following design principle (see Figure 15.2) be used when considering the reform of the safety and quality agenda:

Figure 15.2: A safety and quality design principle

Safety and quality design principle: There should be effective systems of clinical governance at all levels of the health system to ensure continuous improvement in the safety and quality of health care. Good clinical governance makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement. Consumers are central to identifying safety and quality issues and the solutions that need to be implemented.

For improvement to occur, information is critical: of the gaps between care recommended and care received and of the occurrence of adverse events and complications. In addition to ensuring safe practices and that consumers receive effective and appropriate health care, attention to both access and efficiency of service provision is also essential for good quality care.

Source: Australian Commission on Safety and Quality in Health Care

Quality encompasses the errors of over-use and under-use of recommended care, as well as misuse (or errors in care).[15] The Australian Quality in Healthcare Study revealed that 17 per cent of all hospital admissions were associated with adverse events, the majority considered preventable.[16] In a ground breaking study conducted in the USA by Rand Corporation, adults were found to receive a little over half of recommended care (see Figure 15.3).

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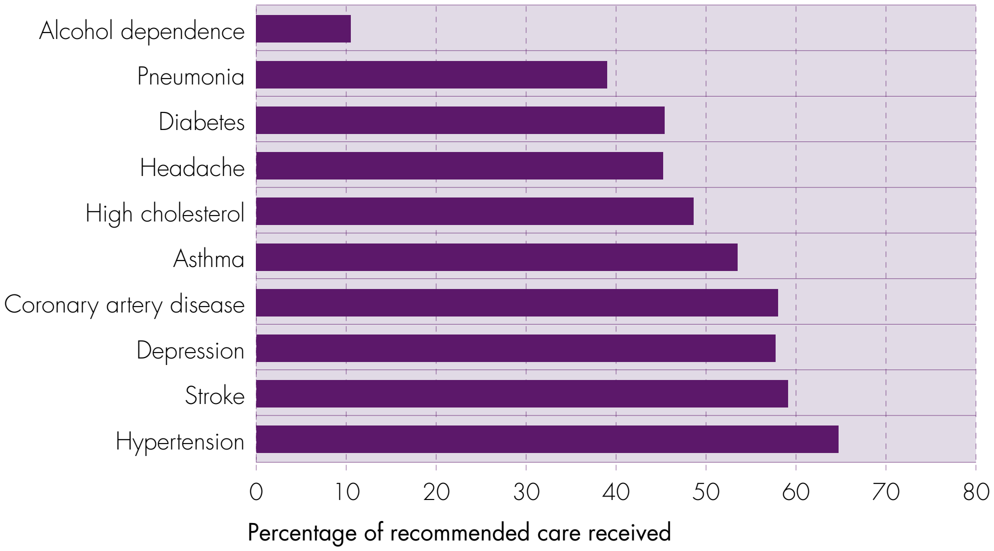
[14] Darzi (2008), High quality care for all: NHS next stage review final report, at: http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825

[15] T Lee (2002), 'A broader concept of medical errors', New England Journal of Medicine (347): 1965–1967.

[16] W Runciman, R Gibberd and colleagues (1995), 'The quality in Australian health care study', Medical Journal of Australia (163): 458–471.

Figure 15.3: Many American patients do not receive the recommended care for common health problems



Source: E McGlynn, S Asche, J Adams and colleagues (2003), 'The quality of care delivered to adults in the United States', New England Journal of Medicine 348 (26):2635–45.

Many think that the care delivered by their doctor is better than the care generally provided in the community. However, the American study shown in Figure 15.3 found that

> … *everyone is at risk of receiving poor care, no matter what their condition, where they live, from whom they seek care, or what their gender, race or financial status is.*[17]

The researchers concluded that system-wide investments in health information technology, such as electronic medical records, automated order entry, decision support tools, and performance tracking and incentives for improvement were all required to improve the quality of care delivered. Whilst a similarly comprehensive study has not been conducted in Australia there is considerable proof that gaps between evidence and practice are commonplace.[18]

Over half of 670 hospitals recently reviewed by the Australian Council on Healthcare Standards for accreditation purposes had inadequate quality control systems for patient safety ■

Over half of 670 hospitals recently reviewed by the Australian Council on Healthcare Standards for accreditation purposes had inadequate quality control systems for patient safety.[19] Accreditation is an important process to safeguard the safety and quality of care, one that has already been recognised by the Australian Commission for Safety and Quality in Health Care as requiring reform based on a clear set of Australian Health Standards.

While accreditation processes around quality and safety will become more stringent, the Internal Medicine Society of Australia and New Zealand note that accreditation processes do not of themselves:

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[17] E McGlynn, S Asche, J Adams and colleagues (2003), 'The quality of care delivered to adults in the United States', New England Journal of Medicine 348 (26):2635–45.

[18] National Institute for Clinical Studies (2003), Evidence-practice gaps report, Volume 1, at: Melbourne).http://www.nicsl.com.au/data/portal/00000005/content/37226001153806799371.pdf

[19] Australian Council on Healthcare Standards (2005), National report on health services accreditation performance: 2003 and 2004, at: www.achs.org.au/

> *… mandate hospitals to implement proven safety practices, or mandate payers (state health departments or private health funds) to withhold funding to hospitals that consistently fail to implement such practices.*[20]

They suggest that too much attention has been devoted to risk managing rare catastrophic events at the expense of common, preventable safety problems such as hospital acquired infection and pressure ulcers. This view was also supported by NSW Health's Quality and Safety Branch[21] who argued for mandatory venous thromboembolism (or blood clot) risk assessment.

The Improvement Foundation believes that it is entirely possible to transform the Australian health system over the next five years, using a systematic, multi-level quality improvement approach which is supported by appropriate government policy.[22] They advocate a bottom-up rather than a top-down approach focusing on rapid change at the implementation level such as their Australian Primary Care Collaboratives (APCC) Program which has increased the capacity of GPs to manage chronic disease. They cite that 560 practices have participated in this program to date with measurable improvements (range: 26–132 per cent) across the whole general practice system for access and health outcomes in diabetes and chronic heart disease. They advocate an expansion of this program and support an 'act locally, measure nationally' approach which provides incentives to encourage collaborative action at the local level whilst monitoring improvement against nationally agreed indicators.

Despite the ultimate success of this program, the Improvement Foundation cautions that, until the participants were able to see for themselves the benefit of measuring and comparing, their initial experience in general practice was that:

> *Data quality is poor and principally driven by low awareness of the benefits of good data capture.*

The Improvement Foundation advocates the need for national policy and investment in national infrastructure to collect and report performance across the health system. While their focus is principally on primary health care, the same message was heard from the acute care sector. A senior quality manager at the Royal Women's Hospital, Melbourne, urges that:

> *a national report of performance reporting should be available at hospital level, rather than only at aggregated state level …*

and,

> *we should think more nationally about the organisations set up to support and resource quality and safety improvement and innovation.*[23]

The Australian Council on Healthcare Standards also argues for a national, but independent, approach to performance assessment. They note that:

> *… having an independent organisation that is both responsive and accountable to the broader industry is important in gaining the confidence and commitment of the health industry and consumers.*

However, they caution that despite their efforts to collect, collate and report on health systems performance over the last decade, little use of trended analyses has been made at either a jurisdictional or corporate level. They cite concerns regarding misuse of data and advocate a more mature approach to public disclosure of performance data.

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[20] Internal Medicine Society of Australia and New Zealand (2008), Submission 103 to the National Health and Hospitals Reform Commission.

[21] NSW Health Quality and Safety Branch (2008), Submission 444 to the National Health and Hospitals Reform Commission.

[22] Improvement Foundation (Australia) Ltd (2008), Submission 101 to the National Health and Hospitals Reform Commission.

[23] M Draper (2008), Submission 265 to the National Health and Hospitals Reform Commission.

Another suggestion received was that investment in data infrastructure and linked data on individual patients will better enable sensible decisions to be made about quality of care and the outcome of that care as a patient 'transitions' through the health system. New research could be locally run and, through linkages, utilise large population data sets to quickly generate data on the quality of care.

A fundamental concern raised about transforming 'intention' into 'action' has been the lack of time and capacity for staff to focus on improvement when they are under siege with workforce shortages and too many patients waiting too long for care (and there may also be financial barriers to the timely translation of research). When hospitals get busy, the immediate need to 'prioritise, hydrate, medicate', with no personal care beyond essential need, leads to burn-out, exhaustion and low intrinsic job satisfaction. The Australian Nursing Federation noted that failing to provide a sufficient, and appropriately skilled, nursing workforce with a manageable workload has:

> *… significant impacts on the safety and quality of care and are key factors in the unacceptably high risks of errors and adverse events that occur in Australian hospitals and health care settings.* [24]

The Royal College of Nursing[25] also suggests that, while levels of nurse staffing and skill mix are strongly linked to high-quality patient outcomes, organisational reform programs that 'free nurses to care' also play a key role. They note that ineffective work patterns lead to a 'disconnect' between patients and nurses with nurses spending less than 40 per cent of their time with their patients. They quote the leadership shown by Flinders Medical Centre in implementing their Redesigning Care Program (based on lean-thinking methodology) and Nursing Works Program as resulting in positive safety, quality, and workforce and cost outcomes.

A national approach is required to guide and drive action across the whole health sector, and commit those accountable for the safety and quality of the health system to align action and reform

- There is a significant strategic gap in leadership and vision around what both safety and quality look like across the whole health sector and how safety and quality can be integrated and actioned across all care settings including general practice, community care, private specialists' rooms, public hospitals, and private hospitals. A national approach is required to guide and drive action across the whole health sector, and commit those accountable for the safety and quality of the health system to align action and reform. However, we believe that existing approaches to safety and quality are too peripheral to guide the systematic reform that is required to improve the safety and quality of health care in the stressed system of the future. Major issues such as approaches to access, service delivery and funding models require reform.

The lack of capacity and expert leadership to establish a culture of quality in safety amongst health services is considered to be a major barrier to continuous improvement. It was argued in one of our submissions that if we want quality in hospitals, then the key change agents – such as the senior management team and the CEO – need to be focused on quality. This might involve basing senior executive remuneration in part on quality improvement performance and identifying the Chief Executive Officer as the person with the greatest impact on quality improvement.[26]

Others who provided their views to us suggest that, while more attention needs to be placed on measuring the quality and safety of care, there is also a need to reward incremental improvements made by health services in better coordinating care. The chronic and complex health needs special interest forum held in Sydney expressed concern about the lack of a system-wide approach to connecting care for patients with chronic disease such as cancer:

> *The cancer journey is fragmented between professions, sectors and levels of government and this impairs quality, increases costs and saps patient and carer morale.*[27]

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[24] F Armstrong (in press), Ensuring quality, safety and positive patient outcomes: why investing in nursing makes ENE, Australian Nursing Federation Issues Paper.

[25] Royal College of Nursing Australia (2008), Submission 164 to the National Health and Hospitals Reform Commission.

[26] P Gross (2008) Submission 448 to the National Health and Hospitals Reform Commission.

[27] Participant (5 June 2008), National Health and Hospitals Reform Commission special interest forum on chronic and complex needs in Sydney.

They concluded that incentive payments or a bonus pool could be used to reward demonstrable improvements in patient outcomes, access, quality or efficiency. The concept of a primary care 'medical home' is gaining currency in the United States as a means of better coordinating the multiplicity of care required by patients with chronic and complex illness, with other component parts (hospitals, specialists).[28] However, it is likely that payment reform, such as financial incentives, would still be required to encourage both hospitals and specialists to reduce over use, by rewarding communication and collaborative decision-making with a patient's primary care medical home. The same policy directions are probably relevant in Australia and mechanisms to better connect multiple providers to improve and strengthen the management of chronic disease in primary health care are addressed in Chapter 3.

It is clearly acknowledged that moving from 'good to great'[29] involves understanding of the problems that lie within. The health system has to engage frontline staff more fully than has previously occurred and support them through education and development to bring about real improvement in care for patients. A greater emphasis needs to be put on measuring and comparing performance and developing leadership skills and capabilities in the use of performance data, linked to incentives that can drive quality improvements.

A recent report from the UK's NHS Institute for Innovation and Improvement[30] comments on the capacity within the UK health system to implement Lord Darzi's recommendations on High Quality Health for All. This report counsels patience and persistence if the benefits of change are to be realised! They propose that four infrastructure elements need to be in place over a sustained period of time (greater than 10 years) to lead to better outcomes. These include: building leadership will and commitment; freeing-up resources for clinical quality improvement; training staff; and establishing indicators and data collection systems.

Realistically they advise that this investment may initially result in a deterioration in performance before it gets better – more efficient data collection systems collect more data but more problems – before the real improvements kick in.

15.4 Creating a better future

15.4.1 Unlocking our research potential – invigoration and collaboration

We believe that there are four crucial elements to integrating and embedding a sustainable clinical research framework into the Australian health system:

1. establishing clinical research networks across a wide range of health services;
2. creating a cohort of clinical research fellows;
3. dedicated funding for health policy, clinical and health services research; and
4. increasing the accountability for all health services to foster clinical and health services research by developing specific reportable indicators.

There are different ways to pursue these objectives. It is not necessarily about choosing one option over another or all options, but about determining the optimum mix.

Teaching and training make research possible, yet these functions are not always appropriately supported by the existing arrangements, and particularly in public hospitals.

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[28] J Wennberg and colleagues (2008), Tracking the care of patients with severe chronic illness: The Dartmouth Atlas of Health Care, at: http://www.dartmouthatlas.org/atlases/2008_Chronic_Care_Atlas.pdf

[29] J Collins (2001), Good to great: why some companies make the leap … and others don't (Harper Collins: New York).

[30] NHS Institute for Innovation and Improvement (2008), The next leg of the journey: How do we make high quality care for all a reality?, at: http://www.institute.nhs.uk/news/quality_and_value/how_to_make_'high_quality_care_for_all'_a_reality.html

The 2003–2008 Australian Health Care Agreements (AHCAs) only make cursory references to teaching, training and research and there is no dedicated funding for this purpose. There is support for changing the way research is treated under the AHCAs and for research funding to be quarantined from service delivery. There is also support for recruiting research-trained clinicians across all disciplines within major teaching hospitals.

Research grants, including those administered by the National Health and Medical Research Council and the Australian Research Council, do not provide 100 per cent funding for the indirect costs of research such as library access, human research ethics processes, information technology, licenses and support to participate in international collaborations. Technology transfer costs and those relating to intellectual property can also be considered legitimate research costs. Health services also struggle to provide administrative support for research functions and capacity to release clinicians from 'service' in order to conduct 'research'. The tension between 'teaching' roles and 'research' roles in universities is similarly fraught.

Research funding should cover both the direct and indirect costs. The Walter and Eliza Hall Institute of Medical Research notes that it is generally accepted that the indirect costs of performing research in Australia amount to about 30 per cent of the total cost (or 50 per cent of the direct costs).[31] While there are various views on the exact quantum of the relationship between indirect and direct research costs, there is complete agreement that the lack of funding of indirect research costs has led to deterioration in basic research infrastructure and research training.[32] Funding the full cost of research will require significant additional funding over time and should not be leveraged by reducing the range or depth of research projects funded.[33]

More health services research is needed to shed light on what interventions work best from a patient's perspective and to explore health outcomes and system improvements ■

The infrastructure required to perform quality research (research administration, physical infrastructure, and equipment and technology platforms) needs new and ongoing investment. Universities Australia's submission notes that research infrastructure support is not keeping pace with project funding provided by the ARC and the NHMRC (25 per cent growth from 2001–06, compared to 200 per cent over the same period).[34]

There is a relative underinvestment in some areas of research, namely health services research and research related to ageing and age-related health issues. Health services research is a multidisciplinary field that involves systematic investigation of health services and the way in which they are provided to help improve health outcomes.[35] It currently constitutes less than three per cent of the NHMRC's budget. More health services research is needed to shed light on what interventions work best from a patient's perspective and to explore health outcomes and system improvements. Research Australia has called for increased health services research funding through the NHMRC, particularly for studies into integrated disease management involving allied health professionals.[36]

We support increasing the number of clinical research fellowships in all health professional groups in order to establish a new cohort of committed researchers who can lead the research momentum across Australian health services. These fellowships should be distributed fairly across hospital and primary health care. Consideration should also be given to alternative models of fostering research careers with combined models of service and research funding for the early years of training.

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[31] Walter and Eliza Hall Institute of Medical Research (2008), Submission 192 to the National Health and Hospitals Research Commission.

[32] Australian Vice Chancellors' Committee (1996), University research: Some issues, at: http://www.universitiesaustralia.edu.au/documents/publications/policy/statements/urissues.pdf

[33] T Cutler (2008), Report on the review of the national innovation system: Venturous Australia – building strength in innovation, at: http://www.innovation.gov.au/innovationreview/Documents/NIS-review-web.pdf

[34] Universities Australia (2008), Submission 461 to the National Health and Hospitals Reform Commission.

[35] Health Research Services Association of Australia and New Zealand (2008), Submission 93 to the National Health and Hospitals Reform Commission.

[36] Research Australia (2008), Submission 158 to the National Health and Hospitals Reform Commission.

Reform direction 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.

Reform direction 15.2

We further propose that infrastructure funding (indirect costs) follow direct grants whether in universities, independent research institutes or health service settings.

Improving knowledge transfer from research to clinical practice is a simple idea. It is about doing what works. Various strategies have been adopted over time to help bridge the gap between the research and health cultures.

- Improving knowledge transfer from research to clinical practice is a simple idea. It is about doing what works

Historically, the university hospitals model was the dominant strategy. This model has a long tradition. The prominent Johns Hopkins Hospital in the US was founded in 1889 and Imperial College, London, was established in 1907. University hospitals have a strong interface between research and health services delivery and have made many significant developments in partnerships with research institutes and pharmaceutical companies. It is argued that Australian teaching hospitals are in danger of falling behind those of other countries in their capacity to monitor quality, innovate and develop new strategic partnerships.

Some researchers, including those that have worked with this model[37] strongly support revamping this model. However, others support rejuvenation of the National Institute of Clinical Studies (NICS) in its role to promote and help clinicians implement the non-binding guidelines developed separately by the NHMRC and others. Researchers consider that the institute has made significant progress in translating knowledge relating to some disease areas.[38]

In April 2007, NICS became an institute of the NHMRC to integrate better the two organisation's functions. While its funding was not cut, it is considered by researchers to be limited ($3.8 million in 2008–09, or approximately 0.7 per cent of the NHMRC's administered funds). The Australian Association of Medical Research Institutes supports designating NICS as the central agency to promote knowledge transfer and giving it an expanded funding base to achieve this – up to one per cent of the health budget by 2020.

Another reform direction proposed by those we consulted with was to strengthen and embed the NHMRC's plans to stimulate collaborative research efforts. The NHMRC recently announced it will fund 50 virtual research centres that function as a highway between research and clinical practice. This collaborative model is popular beyond the health sector for its capacity to inspire innovation. These research centres could focus on the development of collaborative research projects that address preventive health and health services design and delivery issues.

We support building on the NHMRC Centres for Clinical Research Excellence across Australia in a 'hub and spoke' model integrating hospitals, community (including general practice and primary care) and regional hospitals. These new centres should be directed to focus on research programs that look to translate new research findings into interventions that improve the care of patients and their families, or which improve access to, safety in, or efficiency of, health services. Where possible, networks of clinical and health services researchers in hospitals, universities, communities and research institutes should be supported to work in collaborations to develop strengths in particular clinical areas.

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[37] D Penington (2008), 'Rediscovering university teaching hospitals for Australia', Medical Journal of Australia 189 (6):332–5.

[38] Association of Australian Medical Research Institutes (2008), Submission 11 to the National Health and Hospitals Reform Commission.

Reform direction 15.3

We believe that the National Health and Medical Research Council should consult widely with consumers, clinicians and health care professionals to set priorities for collaborative research centres and supportive grants which:

- integrate multi-disciplinary research across care settings in a 'hub and spoke' model; and
- have designated resources to regularly disseminate research outcomes to health services.

More and better data is needed to facilitate health services research. Further investments in health informatics (benchmarking and monitoring), including data linkage systems, are needed to better understand what services are being delivered and the effect on health outcomes. Researchers note that Australia lags behind comparable countries when it comes to electronic health information (e-health). Integration of clinical databases across the nation is seen as critical to tracking patient outcomes and to assessing the impact of changes to clinical practice. Western Australia has made significant headway in the area of linked data. The WA Data Linkage Unit has enabled epidemiological and evaluation studies on heart disease, cancer, birth defects and other health problems.[39]

The plea to 'get going' with electronic, patient-centred information records was heard loud and long

The call for better data linkages would of course be unnecessary if all patients had an electronic information record which could be readily 'mined' for information on diagnoses, care pathways, treatment and health outcomes. The plea to 'get going' with electronic, patient-centred information records, as a rich source of research information and as a pivot for better coordination of safe and high quality care, was heard loud and long:

> *And my completely earth shattering idea is not very surprisingly the speedy and effective deployment of electronic health records into the community. So that we can start reaping the benefits of the measurement of health outcomes and the efficiencies the workforce would enjoy from being able to message each other instead of having to send pieces of paper round and download x-rays instead of having patients sitting around and all that sort of stuff.*[40]
>
> *Our health system really is centred not on patients or individuals, it's centred around the practitioners and the providers, and that's just the way it's evolved historically. So we really don't have a patient-centred system. So it's a huge change to get a system to turn around to be focused on the consumer. I think that means that, for instance, a patient-centred system would mean that we should have a patient-centred information record, so that each person can know that there is a record that contains all of the things that are related to their health, and they're all brought together electronically in the one place, so every person with an interest in their health can access it. So a GP's interventions, a speech therapist's work, a medical specialist of one kind or another, a home care worker, could all see the whole story of what's going on in the person's life. And we just don't have that. At the moment, every practitioner keeps their own records in their own filing cabinet, and no-one else can see them. No collaboration can take place – hopeless.*[41]

The complex and controversial subject of e-health, personal health records and information management is one which we have chosen to defer for further exploration in our final report. The vast number of options suggested to expedite a patient-centred electronic record, and leverage the investment required to roll-out and sustain it in practice, require further deliberation.

15.4.2 Bringing evidence into practice and monitoring outcomes

The Australian health system predominantly involves human activity which introduces issues of politics and group or individual self-interest as well as plain old human error. Any large-scale reform

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[39] Baker IDI Heart and Diabetes Institute (2008), Submission 47 to the National Health and Hospitals Reform Commission.

[40] Health information manager (4 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Sydney.

[41] Consumer (24 June 2008), National Health and Hospitals Reform Commission consultation meeting with community in Melbourne.

has to be cognisant of these realities and complexities. The Australian Commission on Safety and Quality in Health Care recommends the following framework be used to organise a sustained, system-wide reform effort:

Figure 15.4: A national framework for reform in safety and quality

Patient centred health care

- *Consumers know their healthcare rights*
- *Data collection supports comprehensive patient care*
- *Funding models support continuity of care*
- *There is case management for complex care*
- *Electronic health records are available*
- *Patients have access to trusted information*
- *Patients are routinely involved in system improvement*

Performance measurement for safety and quality

- *Data collection provides a return on investment through improved safety and quality*
- *Performance indicators support safety and quality*
- *Public reporting is used where it has benefits*

Build a culture so 'safety is how we do business'

- *Clinicians engaged in organisational safety and quality are supported*
- *Doctors are actively engaged in organisational safety and quality*
- *Legal processes facilitate both incident investigation and open disclosure*
- *There is a clear pathway for public accountability for adverse events*
- *Health facility design incorporates safety and quality input*
- *Safety and quality training is embedded in the work of health care*
- *Providers are able to speak up to keep patients safe*

Systematisation of evidence based health practice

- *Evidence is based on the outcomes of Australian patients*
- *Clinical guidelines are reliable and current*
- *Information systems support safety and quality*
- *Primary care data are available and support safety and quality*
- *Economic information is available to measure the cost of unsafe or poor quality care*

Source: Australian Commission on Safety and Quality in Health Care

We also need to be aware that initial investment in change goes onto the balance sheet, not the operating results, and therefore requires constancy of leadership and sustained investment. Tampering with organisational structures and constantly introducing new policies, initiatives and pilots involves changing direction before the old direction has time to deliver. During our consultation we heard that 'projectitis' and 'pilotitis' were endemic in the health system and that 'change fatigue' was a common complaint.[42] We also heard that health workers were tired of putting effort into pilots which were either not properly evaluated or where funding was discontinued despite showing improved outcomes. There is a need to broker and share innovation and excellence at the national level to reduce duplication of effort and well-meaning attempts to re-invent the wheel.

> *The particular issue I think needs to be noted is that often systems try to encourage innovation and change through funding projects and in the area that I work in we have devised a new term called 'projectitis' – the way of disguising support for innovation by not supporting it because it always comes to an end and is never fully implemented, despite what the evidence*

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[42] P Kuipers (2008), Collaborative review of pilot projects to inform policy: a methodological remedy for pilotitis?, at: http://www.anzhealthpolicy.com/content/5/1/17

> *shows in the project. … So it's, I think, a waste of money to fund projects without a continued commitment to implementing their findings properly.*[43]

> *One of the things I'd really like to see is proper evaluation of new schemes, pilot services. You have to have a proper evaluation of anything new that gets put into the system. It has to be evaluated properly and, if the evaluation shows it works and is effective and has good outcomes, there's gotta be guaranteed funding before that goes into place; because there's nothing worse than wasting everybody's time doing a great pilot, showing great outcomes and then no ongoing funding which is what happens all the time. Even worse is ridiculous schemes that achieve nothing, cost millions and millions of dollars and then for some reason 'cause they're politically nice get funded on an ongoing basis. So I'd really like to sort of see people make sure that everything's done to make our systems evaluated properly before we spend money on them.*[44]

While maintaining and cultivating the capacity of individual health services to innovate is critical, government also has a responsibility to have a facilitating and disseminating role. In the words of Terry Cutler in his Review of the National Innovation System, titled *Venturous Australia*:

> *In the age of the internet, and indeed of Web 2.0, there is less excuse than ever for governments not to do all in their power to cultivate innovation from the 'bottom up'.*[45]

In keeping with our principle on quality and safety, we believe that government should play a part in promoting a culture of excellence and continuous improvement by facilitating the dissemination and uptake of innovation across the health system.

Reform direction 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 their 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 are supported to share best practice lessons by participating in forums such as break-through collaboratives, clinical forums, health roundtables, and the like; and
- a national health care quality innovation awards program is established.

The Australian Commission on Safety and Quality in Health Care has already taken carriage of a large body of work focused on achieving national coordination and local uptake of improvements in health care safety and quality. Accreditation, open disclosure, patient rights, health care associated infection, clinical handover, and standardisation of medication charts are amongst the many projects that have received their attention and evaluation. However, they advocate for a continued national framework for safety and quality reform, and caution patience as reforms have long lead times.[46]

There is clearly no single reform direction that will continuously improve the quality and safety of health care throughout our complex health system. But change has to happen – nationally led, locally managed with the patient at its centre. We believe that a capably led, systematic and well resourced effort which builds capability amongst frontline health personnel – promoting 'inside out' change – will lead to sustainable improvements for every patient. We also need national responsibility for supporting the whole health system to integrate evidence into daily clinical

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[43] Social worker (25 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Melbourne.

[44] Emergency Physician (8 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Perth.

[45] T Cutler (2008), Report on the review of the national innovation system: Venturous Australia – building strength in innovation, at: http://www.innovation.gov.au/innovationreview/Documents/NIS-review-web.pdf

[46] Australian Commission on Safety and Quality in Health Care (2008), Submission 428 to the National Health and Hospitals Reform Commission.

practice and to enable health professionals to better understand how well they are doing in relation to targets or their peers. In combination, these changes will allow health professionals and managers to have the time and capacity to continuously reflect, learn and improve.

We considered the key 'infrastructure' elements required to create the conditions that lead to better and safer outcomes in Australia:

- stimulating collaborative health services research;
- training staff and building capacity to innovate;
- building leadership will and commitment;
- freeing-up resources for clinical quality improvement;
- systematising access to the evidence base and capture of variation; and
- establishing indicators and data collection systems.

Stimulating collaborative health services research is an essential building block which is discussed in section 15.4.2. We believe that educating and training the existing, and new, health workforce in all aspects of safety and continuous quality improvement techniques will build capacity across all professions to foster improvement in care for patients.

Reform direction 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.

However, the evidence suggests that training alone will not deliver the results we need. To embed quality and safety into the day-to-day practice of our staff, they will also require protected time away from service obligations to reflect on results and initiate improvement. This will require expert and pro-active leadership both at the local and national level to create and foster a culture of continuous improvement.

■ To embed quality and safety into the day-to-day practice of our staff, they will also require protected time away from service obligations to reflect on results and initiate improvement

National efforts should be focused on relieving health professionals of the administrative burden associated with systems to collect, report and analyse patients' experience and outcomes, whilst allowing them time to complete Plan, Do, Study, Act quality-improvement cycles.

Reform direction 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.

Consistent with our thinking, the Australian Healthcare and Hospitals Association has strongly advocated for a nationally mandated 'balanced scorecard' of key performance indicators for the health of the entire nation. They emphasise the importance of timely feedback to the place of service delivery as well as to higher levels within the system – national, state/territory, area/region.[47] Women's Hospitals Australasia[48] and Children's Hospitals Australasia[49] also advocate for the national collection and analysis of key performance indicators to allow the handful of speciality

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[47] Australian Healthcare and Hospitals Association (2008), Data and Benchmarking, at: http://www.aushealthcare.com.au/publications/publication_details.asp?pid=153

[48] Women's Hospitals Australasia (2008), Submission 436 to the National Health and Hospitals Reform Commission.

[49] Children's Hospitals Australasia (2008), Submission 435 to the National Health and Hospitals Reform Commission.

hospitals in each state to compare results on patient outcomes and care processes. They note that peer pressure has been shown to be one of the most effective levers in changing practice and improving outcomes. This type of peer group benchmarking also encourages sharing of knowledge and best practice and reduces duplication of effort.

Building a quality performance dimension into local service and employment agreements will also help concentrate the attention of both health professionals and managers. Indeed, there is a growing realisation of the importance of using government funding levers to hasten the reform agenda in safety and quality. We believe that as a starting point financial incentives to reward continuity and quality of care should be adopted.

Further consideration may need to be given to how we reduce serious reportable events – these are extremely rare medical errors that should never happen to a patient ('never' events). The USA-based Leapfrog Group's Position Statement on Never Events[50] advocates for a transparent and supportive approach to 'never events'. This involves giving hospitals the opportunity to receive public recognition for agreeing to: disclose and apologise to the patient and family; reporting of the event to a national or state body responsible for quality and safety; performing a root-cause analysis; and waiving all costs directly related to the event. This links back to our earlier discussion in Chapter 13 about the possible use of 'pay for performance', including the use of incentives and penalties linked to the outcomes of care received by patients.

Reform direction 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 care 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.

Systemisation of the evidence base is not a clinical straitjacket

Another task that would arguably be more efficiently placed at a national level is the development of a system of evidence-based guidelines which are dynamic and incorporate the latest health care evidence on the majority of health conditions. Whilst there is good reason to allow for local adaptation of this evidence base to fit the health service environment in which care is delivered, there is little justification for the wild variance that exists in treating similar patients across Australia. Systematisation of the evidence base is not a clinical straitjacket and, as explicitly acknowledged by Archie Cochrane, it provides clinicians with the capacity to integrate 'individual clinical expertise with the best available clinical evidence from systematic research'. [51]

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[50] The Leapfrog Group (2007), The Leapfrog Group Position Statement on Never Events, at: http://www.leapfroggroup.org/for_hospitals/leapfrog_hospital_survey_copy

[51] D Sackett, W Rosenberg, J Gray and colleagues (1996), 'Evidence based medicine: what it is and what it isn't', British Medical Journal (312): 71–2.

Many countries have already accepted the need for a properly resourced national body to synthesise emerging evidence and translate it into usable clinical practice guidelines. The National Institute for Clinical Excellence in the UK is one example; closer to home the New Zealand Government pioneered the way with the New Zealand Guidelines Group. The UK has recently hot-housed a very innovative web based initiative – the Map of Medicine™ – which combines access to international clinical evidence in an on-line format with wiki functionality and links with diagnostic request forms, search tools and personalised clinician-patient notations (see Figure 15.5). The Map of Medicine™ has already been adopted and implemented by the UK National Health System and is being closely looked at by a number of states in Australia.

Figure 15.5: The Map of Medicine is a tool to encourage evidence-based medicine

The Map of Medicine website describes this endeavour as follows:

The Map of Medicine is a web based visual representation of 400 evidence-based patient care pathways. It covers 28 medical specialties and is designed to present the most up to date synthesised evidence in the form of the pathway of care for specific conditions.

The Map is ideal for the dissemination of national guidelines and for providing pathways across clinical networks. It also enables local pathways to be tailored to meet local service needs.

The Map is especially useful for multidisciplinary teams in primary and secondary care, locum staff and students. It can also be used for service redesign and service planning.

The Map of Medicine is a distillation of recognised international sources of clinical evidence and guidance that are systematically searched and reviewed by information specialists working with experienced clinicians.

Clinical experience is also incorporated through expert review by a large network of external clinicians employed by public sector healthcare organisations.

Source: Map of Medicine http://www.mapofmedicine.com 2 December 2008

Reform direction 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.

Providing easy, timely access for clinicians to the rapidly emerging evidence base is an essential first step, but how do know whether deviation from the scientific evidence in their practice is justified on the basis of a patient's illness or personal preferences? It is likely that there are substantial gaps between what clinicians know works and the care actually provided. The Dartmouth study[52] divided clinical care into three categories:

- Effective care, which consists of evidence-based interventions where the benefits substantially exceed the harms;
- Preference-sensitive care, which encompasses treatment decisions where different choices carry quite different benefits and risks and where patients' preferences are given more weight towards these decisions; and
- Supply-sensitive care, which refers to clinical services where the supply of a specific resource (such as specialists) has a major influence on care utilisation rates.

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[52] J Wennberg and colleagues (2008), Tracking the care of patients with severe chronic illness: The Dartmouth Atlas of Health Care, at: http://www.dartmouthatlas.org/atlases/2008_Chronic_Care_Atlas.pdf

The study concludes that measuring unwarranted variation in each category is crucial to improving the likelihood of a patient receiving the recommended care. They postulate that there is significant over-use of acute care hospital facilities in the USA and significant savings to be gained if a national 'crash program' is commenced which is based primarily on illness severity, medical evidence and the patient's wishes and where resource allocation and health spending are guided more by knowledge about what is needed to produce cost-effective, high quality care. Capturing unwarranted variation in practice will require a system to capture variance and will be the subject of further discussion in our final report.

In the spirit of closing the feedback loop, we believe that all health services, whether public or private, should publicly report on their research and quality improvement activities. Such reporting would be linked to ongoing accreditation and the longer-term use of payments for quality. This will provide transparency to the public and accountability at the health service level for sustaining a continuous learning system.

Reform direction 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.

APPENDIX A – 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 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 between four to six 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 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 the 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 trained paediatrician and a Fellow of the Royal Australasian College of Physicians. She was Head of Health Services Planning in NSW Health and worked with Professor Shearman to lead a major reform of maternity 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, and then Chief Executive of Westmead Hospital and Community Health Services. In between these positions, she was Director of Clinical Services and Population Health in South Eastern Sydney Area Health Service. Subsequently, she was 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 Healthcare 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 Royal Australasian College of Physicians' Council.

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 Chief Executive of the Centre for Healthcare 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 and 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 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 for over 17 years. He was the 19th National President of the Australian Medical Association in 2007 following two years as National Vice President and two years as Victorian State President.

He is currently working with the National e-Health Transition Authority (NEHTA) appraising the clinical health professional community of the benefits of vital role of IT in healthcare. Internationally, he is the Chair of the World Medical Association Finance and Planning Committee.

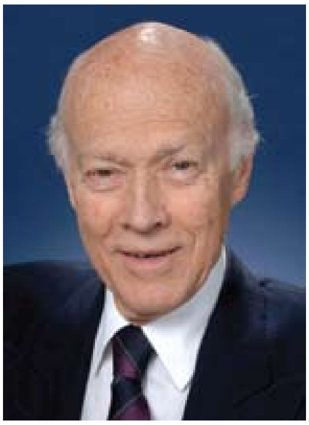
Ms Sabina Knight is a Remote Area Nurse and Associate Professor in Remote Health Practice and Remote Health Management at the Centre for Remote Health in Alice Springs. Since 2003 Ms Knight has been a member of the Regional Women's Advisory Council.

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 nationally and internationally. 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 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 currently Chair of the Mental Health Council of Australia. Mr Knowles is a consultant/adviser in the health sector and has a very high level of expertise in the field of public administration, having been a senior minister in the Victorian Government for seven years, including Minister for 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 Health. He was Director, Centre for Immunology, at St Vincent's Hospital and University of NSW until 2002. He is currently the Co-Chair of the NSW Chronic Aged Community Health Priority Taskforce. Professor Penny was in 1979 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 350 medical and scientific papers in prestigious national and international journals. Professor Penny was previously the Co-Chair of the NSW Government's Chronic and Complex Care Implementation Advisory Group; Chair of the NSW Blood Products Advisory Committee; Chair of the NSW SARS Task Force, and the Ministerial Advisory Council on Medical and Health Research. Professor Penny has served as Honorary Consultant at many Sydney hospitals and was a member of the editorial boards of a number of leading international journals.

He is the Medical Director of Good Health Solutions, a Director of Probiomics, and a 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 – List of discussion papers commissioned by the NHHRC

- *Improving oral health and dental care for Australians,* J Spencer and J Harford, 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 Snowdon
- *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 Wakerman
- *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

These papers are available on the NHHRC website at www.nhhrc.org.au under 'Discussion Papers'.

APPENDIX D – List of submissions to the NHHRC

Number	Name of Organisation or Individual
1	Abatement Technologies Australia
2	Australian Bureau of Statistics (ABS)
3	Accenture
4	ACT Council of Social Services & Women's Centre for Health Matters
5	ACT Health
6	Aged and Community Services Australia
7	Gold Coast Hospital Aged Care Early Intervention Management
8	Australian Institute of Health and Welfare (AIHW)
9	ANU Unit of General Practice & Community Health
10	Australian Private Hospitals Association (APHA)
11	Association of Australian Medical Research Institutes
12	Australian College of Health Informatics
13	Australian College of non Vocationally Registered GPs
14	Australian Nurse Practitioners Association
15	Australasian Podiatry Association QLD
16	Australian Salaried Medical Officers Federation
17	Australian Association of Medical Recruitment Agents
18	William Silvester et al.
19	Australasian College for Emergency Medicine
20	Australasian College of Podiatric Surgeons
21	Australasian Faculty of Rehabilitation Medicine
22	Australian and New Zealand College of Anaesthetists
23	Australian Association of Occupational Therapists
24	Australian Association of Social Workers
25	Australian Cardiovascular Health and Rehabilitation Association
26	Australian College of Ambulance Professionals
27	Australian College of Midwives
28	Australasian Council of Paramedicine
29	Australian Council of Pro Vice Chancellors and Deans of Health Sciences
30	Australian Council on Healthcare Standards
31	Australian Diagnostic Imaging Association
32	Australian Diabetes Educators Association
33	Australian Faith Community Nurses Association
34	Australian General Practice Network
35	Australian Healthcare and Hospitals Association
36	Forum of Australian Health Professionals Councils
37	Australian Health Workforce Institute
38	Australian Institute for Primary Care, La Trobe University
39	Australian Lung Foundation
40	Australian Medical Council
41	Australian Physiotherapy Association
42	Australian Practice Nurses Association
43	Australian Rural Health Education Network
44	Australian Therapeutics Advisory Groups
45	Australian Unity
46	Australian Women's Health Network
47	Baker IDI Heart and Diabetes Research Institute
48	Bio21 Cluster
49	Blackmores Ltd

50 Breast Cancer Network Australia
51 Brisbane South Division of General Practice
52 Caesarean Awareness Network Australia
53 Cancer Voices Australia
54 Cancer Voices Victoria
55 Carers Australia
56 CASE Health
57 Catholic Health Australia
58 Catholic Healthcare Ltd
59 Centre for Military and Veterans' Health
60 Centre for Policy Development
61 Cerner Corporation
62 Chamber of Commerce and Industry WA
63 CHOICE
64 Cobram District Hospital
65 Cochrane Consumer Network in Australia
66 College of Nursing
67 Northern Health Primary Care & Population Health Advisory Committee
68 Complementary Healthcare Council of Australia
69 Complementary Medicines Association
70 Council of Ambulance Authorities
71 Council of Clinical Hypnotherapists
72 Council of Deans of Nursing and Midwifery
73 Council of Remote Area Nurses of Australia
74 CRC for Spatial Information
75 Cystic Fibrosis Australia
76 Defence Health Services Division – Department of Defence
77 Dieticians Association of Australia
78 Doctors Reform Society
79 Doutta Galla Community Health
80 Engineers Australia
81 Faculty of Medicine, Nursing and Health Sciences – Monash University
82 Fitness Australia
83 General Practice Education and Training Limited
84 General Practice Victoria
85 Genetic Support Network Victoria
86 Greater Metropolitan Clinical Taskforce (NSW)
87 Hatrix
88 Headspace
89 Health Care Consumers Association of ACT
90 Health Consumers Alliance of SA
91 Health Consumers Council
92 Health Informatics Society of Australia
93 Health Research Services Association of Australia and New Zealand
94 Health Services Association of NSW
95 Healthscope Ltd
96 Hospital in the Home Australia
97 Hospira Pty Ltd – productivity
98 Human Genetics Society of Australasia
99 IBM Australia
100 I-MED Network
101 Improvement Foundation Australia
102 Inner East Primary Care Partnership Victoria
103 Internal Medicine Society of Australia and New Zealand
104 Johnson & Johnson

105 Mamu Health Service
106 Victorian Maternal and Child Health Coordinators Group
107 Maternity Coalition
108 Medical Technology Association of Australia
109 Medical Deans of Australia and New Zealand
110 Melbourne Health
111 Microsoft Australia
112 Monash Clinical Working Group
113 More and Associates
114 Motor Neurone Disease Australia
115 MS Australia
116 Mount Alexander hospital
117 Municipal Association of Victoria
118 National Ageing Research Institute
119 National Centre for Classification in Health, University of Sydney
120 National Ex-Service Round Table on Aged Care
121 National Association of Testing Authorities
122 National Breast and Ovarian Cancer Centre
123 National Coalition of Public Pathology
124 National GLBT Health Alliance
125 National Institute of Complementary Medicine
126 National Mental Health Consumer and Carer Forum
127 National Seniors Australia
128 Need More GPs
129 Newcastle University Sport
130 NHMRC Centre for Research Excellence in Patient Safety
131 Phillip Bain & Jim Pasinis & Nola Tudball
132 Noise Watch Australia
133 North Queensland Community Service
134 NSW Medical Staff Executive Council
135 NSW Medical Students Council
136 NSW Pain Interest Group
137 NSW Rural Doctors Network
138 Northern Sydney and Central Coast Area Health Advisory Council
139 Optometrists Association Victoria
140 Orthoptic Association of Australia – NSW
141 ORYGEN Youth Health
142 Palliative Care Australia
143 Parkinson's Australia
144 People with MS Victoria
145 Pharmaceutical Society of Australia
146 Plenty Valley Community Health
147 PricewaterhouseCoopers
148 Primary Health Care Research and Information Service, Flinders University
149 Private Hospital Association of Queensland
150 Public Health Association of Australia – SA
151 Public Interest Advocacy Centre
152 Purchasing Index PL
153 Quiet Tasmania
154 Rural Doctors Association of Australia
155 Rural Doctors Association of Australia – Joint Submission on Rural Maternity Services
156 Northern Health (Victoria) Residential Care Intervention Program in the Elderly (RECIPE)
157 Research + Evaluation + Design (RED^3)
158 Research Australia
159 Royal Australian and New Zealand College of Radiologists – Faculty of Radiation Oncology

160	Royal Australasian College of Medical Administrators
161	Royal College of Pathologists of Australasia – Pathology Associations Committee
162	Royal Australian and New Zealand College of Psychiatrists
163	Royal Australian and New Zealand College of Radiologists – Faculty of Radiation Oncology
164	Royal College of Nursing Australia
165	Royal College of Pathologists Australasia – Profile
166	Royal College of Pathologists Australasia
167	Royal College of Pathologists Australasia – Genetics
168	Royal District Nursing Service
169	Royal Victorian Eye and Ear Hospital
170	Mary Draper and Sophie Hill
171	Rural Health Education Foundation
172	Rural Health Workforce Australia
173	SANE Australia
174	Sanofi-Aventis Australia
175	School of Dentistry – University of Adelaide
176	Society of Hospital Pharmacists of Australia
177	Silver Chain
178	South East Healthy Communities Partnership
179	Southern General Practice Network
180	Speech Pathology Australia
181	St Jude Medical Australia
182	Standards Australia
183	TriCare on behalf of CEO Forum Qld
184	University of Melbourne Faculty of Medicine, Dentistry and Sciences
185	UnitingCare Burnside
187	VicHealth
188	Victorian Maternal and Child Health Special Interest Group
189	Victorian Primary and Community Health Network
190	Victorian Healthcare Association
191	Victorian Women and Mental Health Network
192	Walter and Eliza Hall Institute of Medical Research
193	Westmead Children's Hospital – NSW Poisons Information Centre
194	Women's Health Victoria
195	Woolcott Research
196	Wyeth Australia
197	School of Public Health, USYD
198	Work Leisure International
199	Health Insurance Restricted Membership Association of Australia
200	Melbourne Medical Locum Service
201	A Kiss from an Angel
202	Compact Business Systems
203	Victorian Medical Women's Society
204	13CABS
205	Muscular Dystrophy Australia
206	Australian Association for Humane Research Inc
207	Friends of Neringah
208	Laws University of Naturopathy
209	General Practice Queensland and Queensland Health
210	Cancer Voices WA
211	Australian College of Mental Health Nurses
212	Medical Student Council of Victoria
213	Migrant Resource Centre (Southern Tasmania)
214	Australian Privacy Foundation
215	Alzheimer's Australia
216	Terry Ahern (Dr)

217 Brotherhood of St Laurence
218 Australasian Rehabilitation Outcomes Centre, University of Wollongong
219 FORTUS
220 Adrienne Lee
221 Andrew Francis
222 Anna Howe
223 Assoc Prof Roger Gurr
224 Assoc Prof Tom Brett
225 Audrey Robb
226 Carol O'Donnell
227 Christine Hunt
228 Craig Ingham MP
229 Delaune Pollard
230 David Karr
231 Dawn Coombridge
232 Don Howe
233 Douglas Everingham
234 Adrienne Freeman (Dr)
235 Barbara Hayes (Dr)
236 Catherine Crock (Dr)
237 Clare Skinner (Dr)
238 Damian Burns (Dr)
239 David Burke (Dr)
240 Eddie Price (Dr)
241 Ian Smith (Dr)
242 Ian Turnbull (Dr)
243 Jeanine McMullan (Dr)
244 Joan Kavallaris (Dr)
245 John Chu (Dr)
246 Julie Shaw (Dr)
247 Laks Pathi (Dr)
248 Leonard Crocombe (Dr)
249 Michael Williams (Dr)
250 Paul Bennett (Dr)
251 Geetha Ranmuthugala (Dr – UC)
252 Rod Phillips (Dr – Confidential submission)
253 Sarah Latrielle (Dr)
254 Stephanie Davies (Dr)
255 Tanya Robertson (Dr)
256 Thomas Faunce (Dr) and Duy Nguyen
257 Grace Daley
258 Janie Nottingham
259 Jeremy de Constantin
260 Judy Hoskins
261 Chris Moy (Dr)
262 Luke Slawomirski
263 Maggie Sim
264 Marlene Eggert
265 Mary Draper
266 Graham Gorrel (Mr)
267 Ian Bell (Mr)
268 Ian Carter (Mr)
269 Ian McAuley (Mr)
270 Andrea Harcourt (Ms)
271 Shane Doepel (Ms)
273 Olivia Chisholm

274	Paul Burt
275	Gavin Mooney (Prof)
276	Hal Kendig (Prof)
278	Richard Harper (Prof)
279	S T Liaw (Prof) and Doris Young (Prof)
280	Tracey McDonald (Prof)
281	Querida David
282	Rachael Austin
283	Ray Good
284	Roger Hewitt
285	Simone Dalton
286	Tegan Ormston
287	Tonia Zoldosh
288	Tony Lenigas
289	Walter Coffey (Dr)
290	Wendy Porter
291	Tom Shorrock
292	Michael Cameron
293	Sonia Phelan
294	Edmund O'Shea
295	Fernando Blander
296	Norm Morris
297	Jim Sheedy
298	R A Cheasley
299	E D Parr (Mr)
300	Stephen Gibson
301	Tatiana Borisow (Miss)
302	Bruce Hinckfuss
303	P A Hefner (Dr)
304	Robert Johnson
306	Edwin Brooks (Dr)
307	Lyndal Breen
308	M R Tyler
309	Margaret Alva Stewart (Ms)
310	John and Joan Scott (Mr & Mrs)
311	Unknown author
312	Rhonda Kerr
313	Australian Nursing Federation
314	NSW Consumer Advisory Group – Mental Health Inc
315	Royal Australasian College of Physicians
316	Australian Medical Association Council of Doctors in Training
317	Mental Illness Fellowship of Australia
318	Telstra
319	Business Council of Australia
320	Pfizer Australia
321	Pharmacy Guild of Australia
322	Box Hill Institute
323	Healthcare Villages
324	Australian Dental Association Inc
325	Melbourne Institute of Applied Economic and Social Research (University of Melbourne)
326	Daniel Challis (Dr)
327	Diabetes Australia – NSW
328	Paul Nicolarakis (Dr)
329	The Sax Institute
330	Australian Federation of AIDS Organisations Inc
331	Australian Council on Smoking and Health

332	Jonathan McConnell & Tony Smith – Joint Submission
333	National Rural Health Alliance
334	The Health and Productivity Institute of Australia
336	Trevor Hazell (Dr)
337	Cancer Council Australia and Clinical Oncological Society of Australia
338	Monash University School of Rural Health
339	Office of the Privacy Commissioner
340	Department for Planning and Infrastructure (WA)
341	Cancer Council (NSW)
342	Tess and Glenn Williams
343	Barbara Switzer
344	Christina Dwyer
345	Andrea Codega
346	Phil Lowen
347	Jenny Norvick
348	Mandy Bryce
349	Maureen Noonan
350	Tressna Flower
351	Tom Bialkowski
352	Renu
353	Chris Ansted
354	Kwee Ong
355	Mel De La Haye
356	Cisco Systems
357	Danny Samson (Prof)
358	Sharon Tonkin
359	Narelle Green (Mrs)
360	Therese Findlay
361	Jan Price
362	Ashley Mackinnon
363	Jane Cowan
364	Bob Williamson (Dr) on behalf of National Committee for Medicine of the Australian Academy of Science
365	Bunbury Wellington Economic Alliance
366	Nick Argall
367	Ian Conomos
368	John Ward (Prof)
369	Patrick Byrnes (Dr)
370	Yvonne Parry
371	Catherine Taylor
372	Stephen Leeuwenburg
373	Alan Churchill (NOISE)
374	David Lawrence
375	Anthony Richards (Dr)
376	Dominique Griffiths
377	Christina Drummond (Dr)
378	Alex Tahmindjis
379	Ken Brown
380	Andrew McDonell and Auston Balon-Rotheram
381	Gold Coast Institute of Mental Health
382	Gold Coast Medical Association
383	Health Coaching Australia
384	Tara Fuller
385	Sue Roberts
386	Alison Bleaney (Dr)
387	Radicalogic Technologies Pty Ltd (trading as 'rL Solutions')
388	Westfund

389	Ray Good
390	Monash University (Monash Alfred Psychiatry Research Centre)
391	Sara Christopher
392	Jane Dooley
393	Health Consumers of Rural and Remote Australia
394	Graeme Harrison
395	Richard Gorman
396	Phillip Gray (Dr)
397	Julie Head
398	What Women Want (Australia) Inc
399	Confederation of Postgraduate Medical Education Councils
400	Australian Health and Welfare Chaplains Association
401	Nestle Healthcare Nutrition
402	National Heart Foundation of Australia and National Stroke Foundation
403	Sophie Hill and Mary Draper
404	David Dunt (Assoc Prof)
405	Australian Peak Nursing & Midwifery Forum (APNMF)
406	Royal Australasian College of Surgeons
407	Prof Leslie White
408	Hospira Pty Ltd
409	Private Mental Health Consumer Carer Network (Australia)
410	Monash University (Faculty of Medicine, Nursing and Health Sciences)
411	K Soo (Dr)
412	Peter Brooks (Prof) – Executive Dean, Qld University Faculty of Health Sciences
413	Laura Condon
414	Christopher McGowan
415	Rural Doctors Association of Australia – Joint Submission on Rural Specialist Medical Workforce
416	Lynn Hague
417	David Penington (Prof)
418	John Menadue
419	Monash University – Alfred Psychiatry Research Centre
420	Menzies Centre for Health Policy
421	Association for the Promotion of Oral Health
422	National GP and PHC Research Conference
423	Cancer Voices NSW
424	Megan Yarrow
425	Victorian Government – Department of Human Services
426	Jodie Guerrero
427	Lois Logan
428	Australian Commission on Safety and Quality in Health Care
429	Public Health Association of Australia
430	Australian and New Zealand Society of Palliative Medicine
431	National Prescribing Service
432	Marion Morris
433	Australian Mental Health Consumer Network
434	Queensland Nurses Union
435	Children's Hospitals of Australasia
436	Women's Hospitals of Australasia
437	Australian Association of Pathology Practices
438	Australian Psychological Society
439	Queensland Government
440	Aged Care Association Australia
442	Mary de Hayr (Mrs)
443	M Citizen
444	NSW Health – Quality and Safety Branch & Performance Improvement Branch
445	Australian Medical Association

446	Australian Health Care Reform Alliance
447	Barbara Reynolds-Hutchinson and Dr Janet Clarkson
448	Paul Gross, Health Group Strategies
449	Lachlan de Crespigny (Prof)
450	National and NSW Councils for Intellectual Disability & Australian Association of Developmental Disability Medicine
451	Hospital in the Home Society NSW
452	Liz Coombes
453	National Aged Care Alliance
454	Medibank Private
455	Chiropractors' Association of Australia
456	Medicines Australia
457	Sydney Institute of General Practice Education and Training
458	SA Health
459	Australian Disease Management Association
460	Group of Eight Limited
461	Universities Australia
462	Peter Collins
463	Rural Social Workers Action Group
464	Rural Doctors Association of Victoria
465	Dr Lester Cowell
466	Kidney Health Australia
467	Australian Indigenous Doctors Association
468	National Vascular Disease Prevention Alliance
469	Independent Living Centres Australia
470	Palliative Care Service Planning Reference Group
471	Deakin, Monash and Melbourne University Medical Schools
472	National Stroke Foundation
473	Rollo Manning
474	InPsight Community Reference and Advisory Group
475	Margaret Walker
476	David Perry
477	Ron Earle
478	Clive Cawthorne (Dr)
479	Australian Paediatric Society
480	Australian Health Insurance Association
481	Australian Primary Care Community Partnership
482	Graduate School for Health Practice – Charles Darwin University
483	Queensland Aboriginal and Islander Health Council
484	Doctors Reform Society of Western Australia
485	Stuart Jacques
486	Bryanne Barnett (Prof)
487	Mary Gustafsson
488	Joint submission – Queensland Health and Royal Flying Doctors Service
489	Queensland Office of the Public Advocate
490	A W Burnell (Dr)
491	Australian Centre for Health Research
492	Rosanna Busolin
493	Peter Markey (Dr)
494	GlaxoSmithKline Australia
495	Australian Chronic Disease Prevention Alliance
496	About Time Technologies
497	Australian Library and Information Association
498	Karola Mostafanejad
499	Rural Doctors Association of Queensland
500	Mary Draper and Sophie Hill – Joint Submission

501	Joan Byrne (Ms)
502	Work Leisure International
503	Australian Medical Students Association
504	Quality Care at the End of Life Collaborative Stakeholders
505	DebRA Australia
506	Queensland GP Alliance
507	Stephen Bloomer
508	Australian Institute of Medical Scientists
509	Consumers Health Forum
510	Close the Gap Steering Committee for Indigenous Health Equality
511	Royal Australian College of General Practitioners
512	Richard Barnes (Dr)
513	Cameron Martin (Dr)
514	Wagga Wagga Regional Medical Specialist Recruitment & Retention Committee
515	Gippsland Asbestos Related Diseases Support Inc
516	Tom Gordon
517	Lynne Day
518	Australasian Health Complaints Commissioners
519	Michael Marsh (Dr)
520	NT Department of Health and Families
521	Individual
522	National Rural Health Students Network
523	Values in Healthcare Trainers in Australia
524	Neville Crew
525	Shire of Yarra Ranges
526	Leigh Pagonis (Dr)
527	Cooperative Research Centre for Aboriginal Health
528	Easyway Australia
529	Anne & John Moten
530	Jim Lamers
531	Oliver Frank (Dr)
532	Stephen Jansz
533	Oxford Health Alliance
534	Austin Health
535	Keith Beck (Dr)

These submissions can be found on the NHHRC website at www.nhhrc.org.au Some submissions have not been published on the website at the request of the author(s).

APPENDIX E – List of formal consultations conducted by the NHHRC in 2008

21 May	Australian Health Care Alliance Meeting	Canberra
28 May	Frontline Worker Forum	Hobart
29 May	Special Interest Group Forum – Wellness and Prevention	Hobart
29 May	Community Forum	Hobart
2 June	Community Forum	Dubbo
3 June	Government Agency Forum	Dubbo
3 June	Frontline Worker Forum	Dubbo
4 June	Frontline Worker Forum	Parramatta
5 June	Government Agency Forum	North Sydney
5 June	Special Interest Group Forum – Care for People with Chronic and Complex Needs	North Sydney
5 June	Community Forum	Parramatta
11 June	Community Forum	Alice Springs
12 June	Government Agency Forum	Alice Springs
12 June	Frontline Worker Forum	Alice Springs
12 June	E-health Forum	Alice Springs
16 June	Community Forum	Cairns
17 June	Government Agency Forum	Cairns
17 June	Frontline Worker Forum	Cairns
18 June	Australian Peak Nursing and Midwifery Forum	Brisbane
18 June	Frontline Worker Forum	Brisbane
19 June	ACHSE Breakfast Forum	Brisbane
19 June	Government Agency Forum	Brisbane
19 June	Special Interest Group – Acute or Hospital Care	Brisbane
19 June	Community Forum	Brisbane
24 June	Government Agency Forum	Melbourne
24 June	Special Interest Group Forum – Research	Melbourne
24 June	Community Forum	Melbourne
25 June	Frontline Worker Forum	Melbourne
26 June	Special Interest Group – Indigenous	Melbourne
26 June	Community Forum	Shepparton
27 June	Government Agency Forum	Shepparton
27 June	Frontline Worker Forum	Shepparton
2 July	Frontline Worker Forum	Darwin
3 July	Government Agency Forum	Darwin
3 July	Special Interest Group Forum – Indigenous Health	Darwin
3 July	Community Forum	Darwin
7 July	Frontline Worker Forum	Perth
8 July	Government Agency Forum	Perth
8 July	Community Forum	Perth
8 July	Frontline Worker Forum	Geraldton
8 July	Community Forum	Geraldton
9 July	Frontline Worker Forum	Adelaide
10 July	Government Agency Forum	Adelaide
10 July	Special Interest Group Forum – Aged Care	Adelaide
10 July	Community Forum	Adelaide
23 July	Meetings with Peak Bodies *Australian Nursing Federation* *Carers Australia* *Australian Medical Association* *Australian Health and Hospitals Association* *Catholic Health Australia*	Canberra

	Australian Private Hospitals Association	
	Rural Doctors Association of Australia	
	Royal Australian College of General Practitioners	
	Royal College of Nursing	
	Australian Local Government Association	
	Reconciliation Australia	
	National Aboriginal Community Controlled Health Organisation	
	Health and Productivity Institute of Australia	
	Committee of Presidents of Medical Colleges	
23 July	Community Forum	Canberra
24 July	Meeting with Peak Bodies	Canberra
	Australian Dental Association	
	Pharmacy Guild	
	Universities Australia	
	Mental Health Council of Australia	
	Consumers Health Forum	
	Pharmaceutical Society of Australia	
	Society of Hospital Pharmacists of Australia	
	National Rural Health Alliance	
	Australian General Practice Network	
	Australian Health Insurance Association	
24 July	Government Agency Meeting	Canberra
24 July	Frontline Worker Forum	Canberra
5 August	Special Interest Group – Healthy Start	Sydney
12 August	Meeting with CHOICE	Sydney
13 August	Meeting with Australian Council of Social Services	Sydney
21 August	Meeting with Group of 8	Sydney
25 August	Meeting with Allied Health Professionals, Major Diseases Group	
25 August	Special Interest Group – Mental Health	Sydney
7 October	Community Forum	Hobart
7 October	Government Agency Forum	Hobart

Individual Commissioners also made presentations to colleges, associations, and medical and health and community groups and organisations when possible upon request.

Written reports of our consultation forums with members of the community and with frontline health workers are on the NHHRC website at www.nhhrc.org.au under ‘Consultation Reports’.

APPENDIX F – 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.

Glossary

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.

Activity-based funding – Funding based on what services are performed and what kinds of cases are treated.

Acute hospitals – Public and private hospitals which provide services mainly to admitted patients with acute or temporary ailments. The average length of stay is relatively short.

Admitted patient – A patient who undergoes a hospital's formal admission process.

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.

AIHW – Australian Institute of Health and Welfare

Ambulatory care – Care on a non-admitted or outpatient basis.

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 Group (ARDRG) – An Australian version of DRGs that is used to classify most hospital episodes in Australia.

Average length of stay (ALOS) – The average of the length 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 the patients concerned pay nothing. Also known as direct billing.

Casemix – Provides the health care industry with a consistent method of classifying types of patients, their treatment and associated costs. It includes developing and implementing casemix classifications, tools and services.

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) –

A compulsory treatment order 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.

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.

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.

Diagnosis Related Groups (DRGs) – A 'casemix' classification of acute hospital inpatients. People in the same DRG have clinically similar diagnoses and treatments and require similar levels of resources for their treatment.

Elective procedure – A procedure which is clinically necessary but which can be delayed for at least 24 hours.

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.

E-health – The use of digital data – transmitted, stored and retrieved electronically – in support of health care, both at the local site and at a distance.

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.

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.

GP – General medical practitioner

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) – Program 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 whether the body (which includes the mind) is in a good or bad state. With good health the state of the body and mind are such that a person feels and functions well and can continue to do so for as long as possible. See also *public health*.

Health literacy – The knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy.

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, 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 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 – Disturbances of mood or thought that can affect behaviour and distress the person or those around them, so the person often has trouble functioning normally. They include anxiety disorders, depression and schizophrenia.

Morbidity – Refers to ill health in an individual and to levels of ill health in a population or group.

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 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).

Potential years of life lost (PYLL) – Number of potential years of life lost in a population as a result of premature death.

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 all other registered practitioners. It includes community mental health, domiciliary nursing, maternity and early childhood, sexual and reproductive health, and other services.

Primary Care Trust – A UK health service commissioning agency. They are 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.

Private patient – Person admitted to a private hospital, or person admitted to a public hospital who decides 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.

Public health – Term variously referring 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.

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 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*.

Secondary care – Secondary care is community-based, outpatient or ambulatory care specialists.

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 – Specialist is medical specialist, midwives, allied health, pharmacy and dental/oral health services.

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:

1. Resuscitation
2. Emergency
3. Urgent
4. Semi-urgent
5. 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.

Victorian Ambulatory Care 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.