



The interim report of the National Health and Hospitals Reform Commission—a summary and analysis

Rebecca de Boer, Anne-marie Boxall, Amanda Biggs, Luke Buckmaster,
John Gardiner-Garden and Rhonda Jolly
Social Policy Section

Executive summary

In February 2008, the Rudd Government established the National Health and Hospitals Reform Commission (the Commission) to provide a ‘blueprint’ for reforms to the Australian health system. On 16 February 2009, the Commission released its interim report, *A healthier Future for all Australians*.

The interim report proposes 116 ‘reform directions’, covering a wide range of issues including governance of the health system, primary health care, prevention, Indigenous health, hospitals, aged care, workforce, mental health and rural health.

This research paper outlines the Commission’s major proposals, identifies substantial shifts in policy direction and provides commentary and analysis on key issues.

The main conclusions of this research paper are:

- the interim report contains an extensive and thought-provoking set of proposals, some of which, if adopted by the Commonwealth government, would lead to significant changes in the health system
- examples of significant proposals include a Commonwealth takeover of all primary health care funding, policy, and service delivery; a universal, publicly funded dental scheme called Denticare Australia; and proposals for new governance arrangements for the health system
- amidst the large number of proposals, the interim report lacks a single, focused and overarching blueprint for reform and
- the lack of detail in some areas raises several unanswered questions, some of which may be addressed in the final report.

Contents

Executive summary.....	1
Introduction.....	1
The reform context.....	1
Major proposals and shifts in policy direction.....	3
An expanded role in health for the Commonwealth Government.....	3
A renewed focus on prevention and health promotion.....	4
Greater emphasis on social determinants of health.....	4
Introduction of performance payments and incentives.....	5
Greater transparency and public reporting.....	5
Redefined roles and responsibilities for health professionals.....	6
Taking responsibility.....	7
Preventive health in Australia.....	7
Reform directions.....	8
Healthy communities and inequality.....	8
National Health Promotion and Prevention Agency.....	9
Encouraging individual responsibility.....	10
The role of public health?.....	12
Connecting care.....	13
Access to primary care.....	14
Reform directions.....	15
Aged care.....	15
Hospitals and sub-acute care.....	16
Reform directions for hospitals.....	17
Improvements to the sub-acute sector.....	18
Concluding comments.....	18
Facing inequities.....	19
Health inequality in Australia.....	19
Reform directions.....	20
Closing the health gap for Aboriginal and Torres Strait Islander peoples.....	20
Delivering better health outcomes for rural and remote communities.....	22

Supporting people living with mental illness.....	23
Improving oral health and access to dental care	24
Dental health services.....	25
Stakeholder and other responses	26
Costs and benefits.....	28
Concluding comments	29
Driving quality performance.....	29
Funding	29
Governance	30
Option A – Continuing shared state-federal responsibility	31
Option B – Commonwealth takeover of health.....	32
Option C – Social insurance	32
Discussion	33
Workforce issues.....	35
Proposed health workforce reforms.....	36
Stakeholder and other responses	39
Concluding comments	41
Appendix: list of reform directions.....	43

Introduction

Health system reform is rare. Only two major, long-lasting changes to the Australian health system have been implemented since World War II—the introduction of a voluntary, private insurance system in the 1950s; and the introduction of Medicare, a compulsory, tax-funded insurance, in 1984.¹ The release of the National Health and Hospitals Reform Commission's (the Commission) interim report, *A healthier future for all Australians* (the interim report) potentially marks the beginning of a new episode of major health system reform in Australia.² The interim report outlines a range of policy proposals that, if implemented, would substantially change the nature and operation of the Australian health system in the future.

The interim report considers four strategic reform themes—taking responsibility, connecting care, facing inequities and driving quality improvement. It lays out key messages and policy proposals for each of these themes. The Commission will consider feedback on the report and deliver its final report by June 2009.

This research paper outlines the major proposals made by the Commission, identifies proposed substantial shifts in policy direction and provides commentary and analysis on key issues. Stakeholder and commentators' views are discussed in some of the more contentious areas. Considerable attention is paid to key policy proposals, such as the options for new health system governance arrangements and Denticare. The governance models are particularly important because the model chosen will have a powerful influence on other reform proposals made in the interim report. The report does not examine how specific reform proposals would operate under the various governance models proposed and, thus, this has not been explored in this research paper.

The reform context

The Commission was established by the Rudd Government in February 2008 for the purpose of providing a 'blueprint for design and a plan of action to tackle current and future challenges in the Australian health system'.³ The Commission's review of the health system should be considered in the context of other reform initiatives in the health portfolio as these

-
1. The Fraser government introduced a series of reforms to health insurance arrangements that ended ultimately with the dismantling of Australia's first universal health insurance scheme, Medibank. All of these reforms, however, were short-lived.
 2. National Health and Hospitals Reform Commission (NHHRC), *A healthier future for all Australians: interim report*, NHHRC, Barton, ACT, 2009, viewed 18 March 2009, [http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/\\$File/NHHRC.pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/$File/NHHRC.pdf).
 3. C Bennett, 'National Health and Hospitals Reform Commission: developing a blueprint for a better health system', speech to the AMA National Conference, 31 May 2008, viewed 4 March 2009, <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/speech310508>.

may influence the proposals adopted by the Government. Amongst the most significant changes are the new National Healthcare Agreements and National Partnership Agreement on Preventive Health negotiated at the Council of Australian Governments (COAG) meeting in November 2008. These agreements outline outcomes, progress measures and benchmarks across a range of areas, but only the National Partnership Agreement on Preventive Health includes reward payments for achieving defined targets.⁴

In November 2008, COAG also announced a significant funding boost for Indigenous health aimed at closing the gap between Indigenous and non-Indigenous life expectancy in Australia. Funding will be used to improve chronic disease management, help reduce risk factors for ill health and ensure that Indigenous people have better access to health professionals and health services.⁵

Several other major inquiries are also currently underway in the health portfolio. In April 2008, the Minister for Health and Ageing, Nicola Roxon, announced the establishment of a National Preventative Health Taskforce to take responsibility for developing a Preventative Health Strategy by June 2009.⁶ The Government also committed to a Maternity Services Review and the development of a National Maternity Services Plan. In February 2009, the Maternity Services Review released its report, which outlined a range of reform options.⁷ The Government has yet to respond.

There are also over a hundred committees, councils, authorities, statutory agencies, advisory groups and working parties currently operating in the health portfolio, ten of which have been

-
4. R Webb, R de Boer, M Harrington, C Kempner, J Phillips and M Thomas, *Federal Financial Relations Bill 2009*, Bills digest, no. 103, 2008–09, Parliamentary Library, Canberra, 2009, viewed 4 March 2009, <http://www.aph.gov.au/library/pubs/bd/2008-09/09bd103.pdf>.
 5. K Rudd (Prime Minister) and N Roxon (Minister for Health), *\$1.6 Billion COAG Investment in Closing the Gap*, media release, Canberra, 30 November 2008, viewed 16 March 2009, [http://parlinfo.parlInfo/download/media/pressrel/7UJS6/upload_binary/7uj60.pdf;fileType=application/pdf#search=%22\\$1.6%20Billion%20COAG%20Investment%20in%20Closing%20the%20Gap%22](http://parlinfo.parlInfo/download/media/pressrel/7UJS6/upload_binary/7uj60.pdf;fileType=application/pdf#search=%22$1.6%20Billion%20COAG%20Investment%20in%20Closing%20the%20Gap%22).
 6. N Roxon (Minister for Health and Ageing), *New health taskforce on prevention – tobacco, alcohol and obesity priorities*, media release, Canberra, 9 April 2008, viewed 19 March 2009, [http://www.health.gov.au/internet/ministers/publishing.nsf/Content/4EDC8DF94025D30FCA2574260018A47A/\\$File/NR046.pdf](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/4EDC8DF94025D30FCA2574260018A47A/$File/NR046.pdf).
 7. Department of Health and Ageing (DHA), *Improving Maternity Services in Australia: The report of the Maternity Services Review*, DHA, Canberra, 2009, viewed 18 March 2009, [http://www.health.gov.au/internet/main/publishing.nsf/Content/64A5ED5A5432C985CA25756000172578/\\$File/Improving%20Maternity%20Services%20in%20Australia%20-%20The%20Report%20of%20the%20Maternity%20Services%20Review.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/64A5ED5A5432C985CA25756000172578/$File/Improving%20Maternity%20Services%20in%20Australia%20-%20The%20Report%20of%20the%20Maternity%20Services%20Review.pdf).

established by the Rudd Government.⁸ Their influence on policy, however, is difficult to anticipate.

Major proposals and shifts in policy direction

The Commission makes it clear that it continues to support the principle of universal access to care, a commitment to ensuring equity and a mixed public and private health system. Within these parameters, however, the Commission makes numerous major reform proposals. The most significant are: a Commonwealth takeover of all primary health care funding, policy and service delivery; a universal, publicly-funded dental scheme called Denticare Australia (Denticare); and proposals for new governance arrangements for the health system. These proposals and several others contained in the interim report are examined in detail in this research paper.

The interim report also makes many recommendations that, if adopted, would signify major shifts in health policy direction. They include: expanding the role for the Commonwealth Government in health; a renewed focus on prevention, health promotion and the social determinants of health; introducing performance payments and incentives; a greater amount of transparency and public reporting; and redefinition of the roles and responsibilities of some health professionals.

The following section briefly discusses these shifts in policy direction.

An expanded role in health for the Commonwealth Government

Two of the most important proposals that recommend expanding the Commonwealth Government's role in health are Denticare and a Commonwealth takeover of all primary health care. Many other proposals, however, also require a shift in responsibility from the states and territories to the Commonwealth. Some examples of these proposals include: establishing national systems for professional registration, performance reporting, private hospital regulation and workforce education and planning; national leadership on safety and quality in health care; evaluating new technologies, medical devices and prostheses; and creating several new Commonwealth health agencies.

The proposal to expand the Commonwealth's role and responsibilities is significant, primarily because its current role is relatively limited. Under current arrangements, the Commonwealth has responsibility for the Medical Benefits Scheme (MBS), the Pharmaceutical Benefits Scheme (PBS), subsidising private health insurance and funding and regulating a range of other health services. It also shares responsibility for public hospital funding with state and territory governments.

8. LM Russell, A Boxall and SR Leeder, 'Australian government health advisory groups and health policy: seeking a horse, finding a camel', in *Medical journal of Australia*, vol. 189, no. 10, 17 November 2008, pp. 583–85.

A renewed focus on prevention and health promotion

Expenditure on hospitals in Australia far outweighs that allocated to public health activities, such as health promotion, cancer screening, immunisation and environmental health. In 2005–06, total recurrent health expenditure on hospital care was \$31 billion, which was 39 per cent of total health expenditure. In contrast, expenditure on public health activities in the same financial year was \$1.5 billion, or around 1.8 per cent of total health expenditure.⁹

While few would argue for a radical reversal in funding priorities, many health stakeholders have argued for greater investment in preventive health activities.¹⁰ The Public Health Association of Australia, for example, has called for ‘a considerable increase in the percentage of health budgets that go to prevention’. The Association explains that, at present, preventive health activities only receive about two per cent of the health budget, which it considers ‘simply inadequate’.¹¹

Many of the proposals outlined in the interim report, if implemented, would strengthen the role of preventive health in Australia. Some of these proposals would require significant funding increases. Others would require greater coordination and leadership at the federal level. Some of the more important proposals include: establishing wellness and health promotion programs to be delivered by employers and private health insurers; developing ‘Healthy Australia Goals’ for health promotion and prevention; and establishing a national community-based program offering screening for mental health disorders and sexual health for youth.

Greater emphasis on social determinants of health

Responsibility for health is seen as both an individual and collective responsibility. The interim report acknowledges the impact of individual lifestyle risk factors (such as smoking, obesity, and physical inactivity) on the burden of disease, but it also points to a range of powerful ‘social determinants of health’, such as socioeconomic and environmental factors, education, housing and access to clean water and safe food.

Adopting an approach to health that more strongly emphasises the social determinants of health would be a significant policy shift in Australia. Under the Howard Government, the focus of health policy was on individual responsibility and reducing individual risk factors for ill health. It maintained this approach even when attempting to address persistent health

9. Australian Institute of Health and Welfare (AIHW), *Australia’s health 2008*, AIHW, Canberra, 2008, p. 525, viewed 5 March 2009, <http://www.aihw.gov.au/publications/aus/ah08/ah08.pdf>.

10. The term ‘preventive’ has been adopted in this research paper. Where government documents use ‘preventative’, this term has been used.

11. Public Health Association of Australia (PHAA), *Time for action on preventive health*, media release, release, 10 October 2008, viewed 10 March 2009, <http://www.phaa.net.au/documents/MediaReleaseTimeforactiononpreventivehealth.pdf>.

inequities between Indigenous and non-Indigenous Australians. For example, the Howard Government's National Strategic Framework for Aboriginal and Torres Strait Islander Health identified eight priority areas. All but one focused on individual aspects of disease prevention and treatment.¹²

While the interim report has a discernable shift in rhetoric on responsibility for health, it does not specify which proposals, if any, reflect this new approach. The final report may provide more information and clearer direction on how this change in policy direction would be put into practice.

Introduction of performance payments and incentives

The use of benchmarks, targets and goal setting in Australia is not new, but linking them to funding is only a recent initiative. The idea was foreshadowed in the Commission's earlier report, *Beyond the Blame Game*, which outlined a framework for the most recent round of health care agreements.¹³ Until 2007, pay-for-performance measures had not been used in publicly funded health care in Australia. Since then, Queensland has piloted their use in public hospitals.¹⁴ Some of the proposals in the interim report suggest expanding pay-for-performance into other areas such as primary care and aged care.

Greater transparency and public reporting

The interim report makes a number of recommendations for improving transparency and public reporting in the health system. Most aim to standardise data collection, including, making it possible to compare health care and aged care facilities and track progress towards quality improvement. Some recommendations also aim specifically to mark progress on efforts to address health inequity.

-
12. The eight priority areas were: smoking, nutrition, alcohol, physical activity, overweight and obesity; chronic disease management; access to primary health care; sexually transmissible infections; oral health; social and emotional wellbeing (including substance abuse and mental health); urban areas (with a focus on access to health services); and health determinants. D Nutbeam and A Boxall, 'What influences the transfer of research into policy and practice? Observations from England and Australia', *Public health*, vol. 122, 2008, pp .747–53.
 13. NHHRC, *Beyond the blame game: accountability and performance benchmarks for the next Australian Health Care Agreements: a report from the National Health and Hospitals Reform Commission*, NHHRC, Canberra, 2008, viewed 16 March 2009, <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/commission-11p>.
 14. S Duckett, S Daniels, M Kamp, A Stockwell, G Walker and M Ward, 'Pay for performance in Australia: Queensland's Clinical Practice Improvement Payment', *Journal of health services research and policy*, vol. 13, no. 3, 2008, pp. 174–77.

According to an independent survey conducted in 2007, there is strong public support for measures that could increase transparency of hospital performance.¹⁵ The majority of respondents wanted hospital infection and patient readmission rates to be published. They also wanted doctors to make available information on the number of times they had performed an operation and their success rate.¹⁶

The former Health Minister, Tony Abbott, proposed introducing some form of health performance scorecard.¹⁷ There is some international evidence that publishing performance information in the form of scorecards can lead to improvements in the quality of care, especially where these focus on the ‘processes of care’ rather than just the outcomes.¹⁸ The Commonwealth Government abandoned plans to introduce scorecards or league tables for hospitals in January 2008. It did so after encountering strong resistance from the then NSW Health Minister, Reba Meagher, during negotiations on the new health care agreements.¹⁹

While the interim report stops short of recommending the use of league tables or scorecards, it would be possible to construct these if publicly available information was comprehensive and accurate.

Redefined roles and responsibilities for health professionals

The interim report makes three recommendations on roles and responsibilities for health professionals that, if implemented, would lead to significant changes. It proposes to:

- expand the role of nurse practitioners and other registered health professionals in remote and some rural areas and thereby give them access to the MBS and the PBS

15. Ipsos, *Australians supportive of hospital ‘scorecard’*, media release, 12 October 2007, viewed 18 March 2009, http://www.ipsos.com.au/IESRI/lib/Ipsos_MediaRelease_Support-for-Hospital-Scorecard-121007.pdf.

16. Ipsos.

17. M Metherell and N Wallace, ‘League tables for hospitals’, *The Sydney morning herald*, 10 October 2007, viewed 16 March 2009, <http://parlinfo.parlInfo/search/display/display.w3p;adv=yes;db=:group=:holdingType=:id=:orderBy=customrank;page=0;query=tony%20abbott%20hospital%20scorecard%20Dataset%3Aems.radioprms.tvprog.pressrel.pressclp%20|%20External%3AEBSCO,AAP;querytype=:rec=5;resCount=Default>.

18. Canadian Health Services Research Foundation (CHSRF), *Performance reporting to help organizations promote quality improvement*, CHSRF, 2008, viewed 4 March 2009, http://www.chsrf.ca/mythbusters/html/boost14_e.php.

19. ‘State ministers meet to discuss a new federal health care agreement’, *PM*, transcript, Australian Broadcasting Corporation, 31 January 2008, viewed 16 March 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fradioiprm%2FPINP6%22>.

- allow medical practitioners to bill for specified procedural items on the MBS where work has been done by another accredited health professional and
- encourage health professionals working in the proposed Comprehensive Primary Health Care Centres to shift away from fee-for-service practice over time, although this is not specified in the interim report.

The research paper now turns to a more detailed discussion of the interim report's four strategic reform themes.

Taking responsibility

The 'Taking responsibility' section of the interim report emphasises measures aimed at promoting health and preventing illness. According to the interim report, the promotion and prevention focus is driven by factors such as the increasing burden of chronic disease and the unequal health status among particular groups, particularly Indigenous people. This contrasts with other sections, where the emphasis is more on rationalising and/or reforming models of health care funding and delivery.

The interim report focuses on promotion and prevention at two levels:

- the community level (taking a population health perspective) and
- the individual level (from the perspective of how individuals can take greater responsibility for their health).

Preventive health in Australia

Preventive health was a major focus of the Australian Labor Party leading up to the 2007 federal election. Since then, the Minister for Health has spoken about shifting prevention from the margins to the centre of health care because of the growing burden of preventable conditions such as diabetes, obesity, cardiovascular disorders and lung and bowel cancers.²⁰

On 9 April 2008, the Government established the National Preventative Health Taskforce (NPHT). The NPHT is responsible for advising the Government on the framework for the Preventive Health Partnerships between the Commonwealth and the state and territory governments, and developing a National Preventative Health Strategy. The work of the NPHT overlaps with that of other Rudd Government health advisory bodies, the National Primary Health Care Strategy External Reference Group and the NHHRC.

20. S Ryan, 'Roxon to correct underfunding of preventive health care', *The Australian*, 13 February 2008, viewed 16 March 2008, http://parlinfo/parlInfo/download/media/pressclp/LTMP6/upload_binary/ltmp62.pdf;fileType=application%2Fpdf#search=%22Roxon%20health%20%20%20EBSCO,AAP%20australian%22

Local and overseas health policy experts have been arguing for a greater focus on preventive health in their respective countries for many years. Governments in countries such as Sweden and the United Kingdom (UK) have placed an increased emphasis on public health and prevention in recent years as part of their efforts to reform their health systems. Experience from such efforts has highlighted the need for long-term, sustained commitment and engagement at all levels of government if preventive measures are to succeed.²¹

Reform directions

The main reform directions proposed by the Commission at the community level of prevention include:

- proposals for improving the information available to evaluate the health status of the community and to track progress towards the achievement of health objectives and
- establishing an independent national health promotion and prevention agency, which will have responsibility for ‘national leadership’ on ten-year health goals known as ‘Healthy Australia’.²² It will also ensure prevention becomes the platform of healthy communities and is integrated into all aspects of the health care system.

The most notable proposal at the individual level in the ‘Taking responsibility’ reform direction is the inclusion of health literacy as a core element of the National Curriculum (across primary and secondary schools). For a full list of reform directions under the theme of ‘Taking responsibility’, see the appendix to this research paper.

Healthy communities and inequality

The interim report argues against the idea that Australia has a ‘level playing field’ in health and highlights the association between socioeconomic disadvantage and poor health outcomes. It argues that ‘the appalling health status of our Aboriginal and Torres Strait Islander peoples provides the most clear-cut repudiation’ of the position that there are few barriers to accessing health care in Australia and that health is evenly distributed across the population.²³

In a later section entitled ‘Facing inequities’, the interim report proposes measures aimed at addressing inequality among specific populations or people suffering from particular conditions. The main mechanisms for addressing inequality and building healthy communities in the ‘Taking responsibility’ section revolve around collecting and reporting

21. L Russell, G Rubin and S Leeder, ‘Preventive health reform: what does it mean for public health?’, *Medical journal of Australia*, vol. 188, no. 12, 2008, p. 718.

22. ‘Healthy Australia’ goals are a rolling series of ten-year goals for health promotion and prevention.

23. NHHRC, *A healthier future for all Australians: interim report*, p. 54.

data on health status and setting specific, long-term goals for improving health outcomes. These include proposals for a regular report tracking our progress as a nation on health inequity and a rolling series of ten-year goals for health promotion and prevention, to be known as Healthy Australia Goals and commencing with Healthy Australia 2020 Goals.

These proposals are tentative first steps towards addressing inequalities in health status across the community. It is likely that better information about the nature of the problem and specific agreed targets for health improvement (against which Government performance will be measured) will also help focus health policy and programs around the problem of health inequality.

However, it is likely that much more than information and goal-setting will be required. The interim report is relatively quiet on the policies that might transform information about the nature of the problem into improved outcomes. It makes some interesting (albeit tentative) comments about the need to target disadvantaged groups (for example, ‘targeting within universalism’), without saying very much about specific ways in which this might be done. The interim report refers to several examples (more inclusive health screening programs and needs-based funding) from submissions to the Commission and states that it welcomes feedback on the issue. Given the centrality that the interim report gives to addressing health inequality as part of building healthier communities, it will be interesting to see whether the Commission provides more direction on this matter in its final report.

National Health Promotion and Prevention Agency

One of the main reform directions proposed by the Commission is the establishment of an independent national agency with responsibility for leadership and coordination of preventive health activities, the National Health Promotion and Prevention Agency (NHPPA). As the interim report notes, the idea of an agency like the NHPPA is not new. There have been calls for such an agency since the 1970s, including, most recently, from the NPHT.

According to the NHPT, recent experience of public health in Australia shows that ‘preventative efforts have been most effective when effective supports have been put in place’.²⁴ Establishing an agency with responsibility for health promotion may also help ensure that such efforts are sustained and engage all levels of government.

The interim report advances some preliminary ideas as to how such an agency might be established, funded and operated, including that it be independent (preferably established by statute), have reasonable funding certainty, be cross-portfolio in scope and report directly to the Prime Minister and the Parliament. It also suggests that the functions of the NHPPA 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

24. NHHRC, *A healthier future for all Australians: interim report*, p. 68.

and educational campaigns; and leading cross-sectoral action on health promotion and prevention.²⁵

The agency would also be responsible for the collation and dissemination of ‘information about the efficacy and cost effectiveness of health promotion and prevention interventions’.²⁶ This is an impressive list of responsibilities. One can reasonably assume that, in order to do its job properly, substantial funding will be required. This may pose a challenge to policy makers in the current financial climate.

Something more substantial than establishing a single agency might also be required to ensure that prevention is prioritised in Australia. As the interim report acknowledges, prevention is about far more than what happens in what is generally thought of as the health care system (clinics, hospitals, doctors’ surgeries). In some countries, more fundamental changes—such as separating out public health functions from the administration of the rest of the health system—have been needed to prioritise the prevention agenda.²⁷ Sweden, for example, has a Ministry for Public Health and an independent Institute of Public Health—both underpinned by a national public health policy and legislation mandating that the public health aspects of all government decisions be considered.²⁸ It has been argued that an approach of this nature (based around a separate government department of public health with substantial funding, responsibilities and powers) might be required in Australia to achieve necessary change in the area of prevention.²⁹

Encouraging individual responsibility

The interim report includes several proposals for improving the capacity of individuals to take greater responsibility for their own health. The first supports strategies that aim to ‘make healthy choices easy choices’, including ‘individual and collective action to improve health by people, families, communities, health professionals, employers and governments’.³⁰ This idea is not developed in the interim report. Rather, it refers to future work by the NHPT ‘on strategies to make healthier choices in areas including obesity, tobacco and alcohol’.³¹ A broader approach to the problem might also consider additional impediments to healthy

25. NHHRC, *A healthier future for all Australians: interim report*, p. 68.

26. NHHRC, *A healthier future for all Australians: interim report*, p. 68.

27. L Russell, G Rubin and S Leeder, ‘Preventive health reform: what does it mean for public health?’, *Medical journal of Australia*, vol. 188, 2008, p. 718.

28. Russell, Rubin and Leeder, ‘Preventive health reform: what does it mean for public health?’, p. 718.

29. Russell, Rubin and Leeder, ‘Preventive health reform: what does it mean for public health?’, p. 718; and S Corbett, ‘A ministry for the public’s health: an imperative for disease prevention in the 21st century?’, *Medical journal of Australia*, vol. 183, no. 5, 2005, pp. 254–7.

30. NHHRC, *A healthier future for all Australians: interim report*, p. 73.

31. NHHRC, *A healthier future for all Australians: interim report*, p. 73.

choices such as the cost of healthy food, inadequate public transport and the design of urban environments.

The interim report makes much of the need to improve health literacy as part of efforts to encourage individual responsibility in health and presents data showing that three out of five adults lack basic proficiency in health literacy. It proposes that health literacy be included as a core element of the National Curriculum for schools, and that it be incorporated into national skills assessment. There is obvious merit in seeking to improve people's capacity to understand basic health issues. However, it may be that the National Curriculum does not provide the best avenue for advancing health literacy, given its current focus on core subjects like maths, science and English. An alternative approach might be to pursue something more targeted along the lines of the Commonwealth's Financial Literacy in Schools program.³²

The interim report also notes the importance of good information as the basis for making decisions about health. As such, reform direction 1.1 encourages:

... 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.³³

More direction could be provided to strengthen this proposal. Arguably, the public does not lack information about lifestyle and health (given the enormous proliferation of such material on the Internet) but rather access to a central source of trustworthy and credible information. Rather than leave this to 'relevant groups', this could possibly be a role for the Department of Health and Ageing and/or the proposed NHPPA (perhaps along the lines of the Victorian Government's *Better Health Channel* website).³⁴

Overall, while there may be some gains available through enhanced health literacy and access to information, there are likely to be limits to any such gains. There is a range of other factors that affect a person's ability to take control of their health care, including the communication styles of health professionals, the continuing imbalance of knowledge between the health professional and patient and the sense of powerlessness of many patients when faced with those in a professional role. This suggests the importance of understanding the notion of choice in health in a broader context.

32. Australian Government Understanding Money Pays Off website, *Financial literacy in schools*, viewed 4 March 2009, <http://www.understandingmoney.gov.au/content/education/youngpeople/professionaldevelopment.aspx>.

33. NHHRC, *A healthier future for all Australians: interim report*, p. 76.

34. Victorian Government, 'Better health channel', <http://www.betterhealth.vic.gov.au/>, viewed 19 March 2009.

The role of public health?

Some public health experts argue that some of the biggest gains in preventive health are to be made in areas where individuals do not exercise individual choice (such as water fluoridation, sanitation and food regulation), or where there are measures in place to ensure the widest possible compliance (such as vaccination).³⁵ For example, UK public health expert, Nicholas Wald, arguing for a stronger approach to intervention in nutrition and other areas of public health, states:

Contrary to current perception, the key to effective public health is not individual choice but collective action linked to public trust in its value. Most of the main determinants of health vary little among people in a community. The scope for individuals to choose healthy and safe foods, drinks, transport, or buildings is limited; the similarities in exposure are greater than the potential differences.³⁶

On the issue of nutrition, Wald goes on to say:

The chief merit of the increasingly popular convenience foods is their convenience. Individuals have little influence over their composition. Even foods that are described as being healthy can be high in sugar and salt, counterbalancing any benefit from added micronutrients, such as folic acid. But discouraging the use of convenience foods is not practical; we need collective action to reduce the amounts of salt, sugar, and saturated fat in foods, and a sensible policy on portion sizes in restaurants.³⁷

Public health arguments such as these highlight the difficult choices governments face when seeking to make significant gains in the area of prevention (for example, between paternalism and individual freedom). The interim report says little on these matters. Overall, this reflects the lack of emphasis it gives to specific action in the area of primary prevention—that is, public health measures seeking to control exposure to risk and promoting protective health factors at the population level.³⁸ Arguably, it is important that this be addressed given the substantial contribution to health made by public health measures throughout the 20th century—far in excess of the contribution made by medical interventions.³⁹

35. G Oakley and R Johnston, 'Balancing benefits and harms in public health prevention programmes mandated by governments', *British medical journal*, vol. 329, 3 July 2004, pp. 41–4.

36. N Wald, 'Commentary: silent prevention', *British medical journal*, vol. 329, 3 July 2004, p. 44.

37. Wald, 'Commentary: silent prevention', p. 44.

38. Russell, Rubin and Leeder, 'Preventive health reform: what does it mean for public health?', p. 716.

39. B Bloom, 'The future of public health', *Harvard public health review*, Fall 2000, viewed 11 March 2009, http://www.hsph.harvard.edu/review/review_2000/specialfoph.html.

Some public health experts argue that focusing on this area through a revitalised public health strategy represents the most sustainable way to address the problems of health inequality and chronic disease.⁴⁰ It will be interesting to see if the final report provides any more detail on how to approach prevention activities that lie outside health clinics and doctors' offices.

Connecting care

The Commission is quite clear about the importance of primary care. It states that 'primary care must be the foundation of our future health system'.⁴¹ To that end, the 'Connecting Care' section of the interim report puts forward 51 reform directions, approximately half of the total number of reform directions it makes. The major recommendations from this section are: for the Commonwealth to take responsibility for primary care, improvements to the administration of hospitals to facilitate greater access and changes to the aged care sector to enhance greater competition and choice for consumers.

The definition of, and approach to, primary care articulated by the Commission is broad. It is described as services in the 'community accessed directly by consumers' ranging from general practitioners, pharmacists, allied health, dental care, mental health services, domiciliary nursing, alcohol and drug treatment services and school health, amongst others.⁴²

As noted by the World Health Organization in its declaration on primary health care in 1978, primary care is more than just the first point of contact with the health care system. It encompasses a preventive, multi-sectoral approach with an emphasis on health promotion and community participation.⁴³ In many respects what the Commission proposes is consistent with the Declaration; the establishment of Comprehensive Primary Health Care Centres (CPHCC), a lifecycle approach to primary care and prevention, systemic intervention at various stages of the lifecycle (primarily birth), specific measures for chronic and complex illness and those with special needs, as well as reform to hospitals and the aged care sector to improve co-ordination of care and linkages across the health care system.

Nevertheless, the Commission's approach appears at times to be fragmented, with separate initiatives to address each of these challenges. For example, it could be argued that the establishment of the CPHCC as well as the proposed Divisions of Primary Health Care may

40. Bloom, 'The future of public health'.

41. NHHRC, *A healthier future for all Australians: interim report*, p. 81.

42. NHHRC, *A healthier future for all Australians: interim report*, p. 81.

43. World Health Organization, 'Declaration of Alma Ata', International Conference on Primary Health Care, Alma-ATA, USSR', 6–12 September 1978, viewed 16 March 2009, http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.

lead to overlap, poor coordination of care, and increased bureaucracy.⁴⁴ However, this apparent fragmentation does not apply to all of the reform directions. For example, the proposal for implementing personal electronic health records would be of great benefit to consumers and health care professionals alike and would be a comprehensive solution to some of the difficulties encountered when navigating the health care system.

Access to primary care

As noted in the interim report, access to primary care is a significant challenge facing Australia's health care system. This is due in part to historical factors that have shaped the organisation and funding of health care, but also to a growing workforce shortage. The National Secretary of the Australian Nursing Federation, Ged Kearney, goes further and claims:

...at the moment, all funding follows the doctor. So, really, the only person who has access to the primary health care system are GPs. Now that inherently has caused, in my opinion, all the problems with the health care system.⁴⁵

It appears that the Government is prepared to consider changes to improve access to primary care. On more than one occasion the Minister for Health has suggested that nurses, pharmacists and other allied health practitioners take on a more substantial role in the provision of primary care. Furthermore, Minister Roxon has openly canvassed the option of granting other health professionals' access to the MBS, an idea that has attracted criticism from the Australian Medical Association (AMA).⁴⁶

As part of its election platform, the Rudd Government pledged to establish GP Super Clinics, which are similar to the CPHCC proposed by the Commission.⁴⁷ The objectives of the Super Clinics are 'affordable, high quality, comprehensive primary care' with a 'greater focus on health promotion, illness prevention and improved coordination'. The first of the Super Clinics is currently being established.

44. The proposed Divisions of Primary Health Care are an extension of existing Divisions of General Practice with expanded responsibilities and a greater focus on provision of primary care.

45. N Miller and L Shanahan, 'Tell me where it hurts', *The Age*, 21 February 2009, viewed 16 March 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpre-ssc1p%2FC9US6%22>.

46. See, for example, the address by the President of the Australian Medical Association (AMA), Dr Rosanna Capolingua, to the National Press Club: R Capolingua, 'Advocating for patients in health reform', *National Press Club address*, 18 June 2008, viewed 13 March 2009, <http://www.ama.com.au/node/3320>.

47. Capolingua, 'Advocating for patients in health reform'.

Reform directions

Two dominant themes emerge from the ‘Connecting care’ section of the interim report—these are that the Commonwealth has sole responsibility for primary care and improving the coordination of care. The interim report suggests that a single point of responsibility and accountability will lead to greater equity and better funding arrangements.⁴⁸ However, the role of state and local governments under these arrangements is not addressed and there is no suggestion as to who might provide additional primary care services. Furthermore, the interim report is silent on the proposed funding mechanisms and how the current tensions between the Commonwealth and state health budgets for the provision of primary care where one is capped (the states) and the other is uncapped (the Commonwealth) budget and might be resolved.

Poor coordination of care is a problem across the health system, not just in hospitals or general practice. Therefore, it is not clear how sole responsibility for primary care by the Commonwealth will improve coordination of care, which is the very issue it aims to address. Furthermore, the role of Medicare in this approach has not been articulated.

While there are many reform directions in the ‘Connecting Care’ section of the interim report worthy of further consideration, the focus in this research paper is limited to aged care and hospitals.

Aged care

The aged care recommendations are consistent with the broader reform objective of consolidating responsibility for funding and policy under the Commonwealth. The interim report also encourages greater competition in aged care, less regulation and greater consumer involvement in decisions about how aged care subsidies are spent. Of note are the reform directions that suggest allowing the use of accommodation bonds in residential aged care and providing funding for aged care to care recipients rather than places.⁴⁹ This would essentially amount to a voucher system which, if implemented, may allow for greater consumer involvement in aged care and competition in the sector.

The interim report notes that the demand for aged care is increasing. It proposes to change the ratio of places per 1000 people aged 70 or over to care recipients per 1000 aged 85 or over to reflect the changing demographic and ageing profiles of older Australians. This would

48. NHHRC, *A healthier future for all Australians: interim report*, p. 88.

49. Currently aged care is funded according to the number of places set by the Commonwealth Government.

increase the number of residential and community care places available and enable many more older Australians to access subsidised aged care.⁵⁰

Many of the reform directions are consistent with what has been advocated previously in the Hogan Review of Pricing Arrangements in Residential Aged Care⁵¹ and the Productivity Commission's report on trends in aged care services.⁵² However, unlike those reports that called for more deregulation and competition, the Commission has not advocated complete deregulation of the sector but a 'hybrid approach' to regulation, whereby the number of places is no longer limited to the number of places funded by the Commonwealth. This would enable aged care providers to offer additional services based on perceived need. The Commission also advocates better integration of Commonwealth aged care programs so that older Australians can remain in the community longer.

The Aged Care Association of Australia has welcomed these recommendations, particularly the changes to bonds and to aged care assessments.⁵³ In addition to support for changes to the planning ratio, Catholic Health Australia also supports the introduction of accommodation bonds.⁵⁴

Hospitals and sub-acute care

The Commission notes the strengths of Australia's public hospital system, namely the provision of high quality care that is free of charge at the point of delivery. The main changes it proposes concern the internal workings of hospitals and their linkages outside to other sectors such as the aged and community care sectors. The Commission also noted the gaps in

-
50. Catholic Health Australia (CHA), *New approach needed to ensure enough aged care*, media release, 22 February 2009 viewed 16 March 2009, <http://www.cha.org.au/site.php?id=1691>.
 51. The Hogan Review was completed in 2004 and examined the long-term operation of residential aged care services. It made a range of recommendations, notably increased flexibility in planning arrangements and greater competition in the sector. It also advocated the introduction of vouchers. See: WP Hogan, *Review of pricing arrangements in residential aged care*, Commonwealth of Australia, Canberra, 2004, viewed 10 March 2009, [http://www.health.gov.au/internet/main/publishing.nsf/Content/A8F308F0C773C502CA256F18005083CC/\\$File/full_report.pdf.link](http://www.health.gov.au/internet/main/publishing.nsf/Content/A8F308F0C773C502CA256F18005083CC/$File/full_report.pdf.link).
 52. The Productivity Commission also advocated increased flexibility in aged care and regulatory reform. See: Productivity Commission, *Trends in aged care services*, Canberra, Productivity Commission, 2004, viewed 10 March 2009, <http://www.pc.gov.au/research/commissionresearch/aged-care-trends>.
 53. Aged Care Association Australia, *NHHRC recommendations on aged care welcome*, media release, viewed 16 March 2009, <http://www.agedcareassociation.com.au/content/NHHRC%20medial%20release%2016%20Feb%2009.pdf>.
 54. Catholic Health Australia, *Health Commission reopens debate on bonds in high care*, media release, 16 February 2009, viewed 16 March 2009, <http://www.cha.org.au/site.php?id=1674>.

health care service provision in the ‘sub-acute’ sector, particularly rehabilitation services.⁵⁵ There are three main proposals for hospital reform: the introduction of activity-based funding, reform of emergency departments to improve access and integration with other parts of the health care system (including within the hospital), and contracting out of elective surgery or establishing specific centres to perform selective elective surgery procedures.

Consistent with the Commission’s focus on performance and reporting, National Access Guarantees for planned procedures and National Access Targets for emergency care would also be developed. Achievement of these would be linked to bonus payments as part of the funding for public hospitals. The Commission also recommends introducing activity-based funding (commonly known as case-mix) for all public hospitals.

These changes would be supported by the proposed improvements to the sub-acute sector. These are considered by the Commission to be the ‘missing link’ in the health care system and include services that are provided in the community, usually after hospitalisation such as rehabilitation, geriatric evaluation, and ‘step-down’ programs.⁵⁶ Currently there is significant variation between states, major gaps in service provision and a lack of continuity of care in the sub-acute sector.

Reform directions for hospitals

According to the Commission, hospitals ‘... are where most babies are born and where many people die ... and it is crucial that we make the best and most efficient use of these vital and expensive services’.⁵⁷ Many of the recommendations suggest changes to the organisation and performance of hospitals and the use of clearly defined targets linked to bonus payments. Improved data collection and the introduction of national activity-based funding are considered essential. The interim report also recommends a single funder for in-patient and specialist medical care to encourage greater efficiency in the sector and limit cost-shifting.

The interim report notes that waiting lists for elective surgery were longer in 2006–07 than in the preceding four years.⁵⁸ It also notes the shift of surgeons from the public to private sector, placing greater demands on elective surgery waiting lists. The interim report supports the idea of contracting surgical procedures from public to private hospitals and developing specific hospitals, or units within hospitals, for planned elective surgery procedures. Potentially this would enable hospitals to reduce over-crowding and improve access to emergency care.

55. In the interim report, ‘sub-acute services’ is broadly defined as multidisciplinary in approach with a strong reliance on specialist allied health staff and medical specialists such as rehabilitation medicine specialists and geriatricians.

56. NHHRC, *A healthier future for all Australians: interim report*, p. 145.

57. NHHRC, *A healthier future for all Australians: interim report*, p. 119.

58. NHHRC, *A healthier future for all Australians: interim report*, p. 125.

The reform directions put forward have a strong focus on accountability, public reporting and data collection and linkage. In many respects this is no different to what has been incorporated in the National Partnership Agreements but these recommendations go much further by explicitly linking performance with bonus payments. Furthermore, the recently signed National Healthcare Agreement requires a ‘nationally consistent approach’ to activity based funding within five years. The role of private hospitals and how they might be better integrated with public hospitals is not covered in the interim report. There are around 543 private hospitals in Australia, many of which could be used as part of the solution to a more efficient and effective hospital sector.

Many of the reform directions put forward by the Commission require extensive data collection and analysis by state, territory and Commonwealth Governments. Currently the health care system lacks the capacity to capture the data required to implement the interim report’s recommendations and significant resources as well as expertise would be required to achieve these goals. It will be some time before this capacity is available. More data will not necessarily lead to better health outcomes or more efficient health expenditure. As a result, it might be argued that more attention might also be given to how existing data can be used more effectively and to identifying what additional data is required to achieve the desired health and administrative outcomes.

Improvements to the sub-acute sector

The Commission notes that ‘no government—whether state or Commonwealth—is being held accountable for non-performance’ in sub-acute services.⁵⁹ This, according to the Commission, has led to uneven access and disparate services across Australia and to poor outcomes for patients. As for many of its other recommendations, the Commission proposes an activity-based funding model, the development of clear targets and improved data collection with the Commonwealth having responsibility.

Sub-acute care is broadly defined as multidisciplinary with a strong reliance on specialist allied health staff and medical specialists such as rehabilitation medicine specialists and geriatricians.⁶⁰ To implement sub-acute care in the way that has been envisaged by the Commission, a significant increase in the health workforce and in funding would be required. Any achievable improvements to the sub-acute sector may well reduce pressure on other aspects of the health care system.

Concluding comments

There has been little stakeholder comment about aspects of the interim report addressing the theme of ‘Connecting care’. Some of the reforms in this section have already been implemented to varying degrees by the Rudd Government. Perhaps the most valuable reform

59. NHHRC, *A healthier future for all Australians: interim report*, p. 151.

60. NHHRC, *A healthier future for all Australians: interim report*, p. 147.

direction, and possibly the most difficult to implement, is a coordinated approach to the provision of primary health care. Irrespective of the governance model adopted, this coordination would require greater cooperation among the medical professions and a cultural shift towards a systemic, multidisciplinary approach to primary health care.

Facing inequities

The ‘Facing inequities’ section of the interim report addresses the various inequities of health access, status and outcomes in Australia. It focuses on four main areas: Indigenous health, rural and remote health, mental and oral health, and dental care.

The interim report makes the point that addressing inequity in the health system is not simply about making sure everybody has access to the same services or funding. Because overall need for certain groups is unequal, ‘the level of resources needs to be proportionate to the greater health problems and disadvantaged’.⁶¹

Health inequality in Australia

Overall, Australians have high and improving levels of health. Australia matches or leads other comparable countries on most measures of health status.⁶² For example, Australians enjoy one of the highest life expectancies in the world (81.4 years), second only to Japan.⁶³

However, particular groups in Australia suffer from significantly poorer health status than Australians in general. They include socioeconomically disadvantaged Australians, Indigenous people, people living in rural and remote areas and prison inmates.⁶⁴

Factors that contribute to unequal health outcomes are the same as those that contribute to inequality more generally—age, sex, ethnicity, gender, social and economic status, disability and geographical location. While some factors, such as age, are unavoidable, other factors contributing to inequality, such as socioeconomic differences, access to educational opportunities, safe working conditions, effective services, living conditions in childhood, racism and discrimination, are all amenable to change.⁶⁵

This section of the interim report, while acknowledging the broad range of social determinants of health, mainly focuses on the problem of how elements of the health system might be changed in order to address health inequality. In this respect, a broad criticism of

61. NHHRC, *A healthier future for all Australians: interim report*, p. 13.

62. AIHW, *Australia’s health 2008*, p. 6.

63. AIHW, *Australia’s health 2008*, p. 18.

64. AIHW, *Australia’s health 2008*, p. 62.

65. AIHW, *Australia’s health 2008*, p. 63.

this section is that it does not adequately address the contribution of inequality overall (for example, socioeconomic inequality) to health inequality.

Consequently, the absence of a clear focus on inequality per se is probably reflected in the selection of reform areas covered by this section. While mental health and oral health are obviously important and bear some relationship to inequality, it is questionable whether they are issues of inequality or something else, such as issues of primary care. This is not mere semantics but rather a problem that goes to the core of the approach taken in addressing an important and complex issue.

Reform directions

Key recommendations in the ‘Facing inequities’ section of the interim report include:

- the establishment of a National Aboriginal and Torres Strait Islander Health Authority (which would play a similar role in Indigenous health to that played by the Department of Veterans’ Affairs in the area of veterans’ health)
- funding mechanisms aimed at ‘bringing care to the person or the person to the care’ in remote and rural locations (for example, through networks of primary health care services, telehealth services and ‘on-call’ 24-hour telephone and internet consultations and advice)
- a youth-friendly community-based service, which provides information and screening for mental disorders and sexual health, to be rolled out nationally for all young Australians, and
- the introduction of a new scheme, Denticare Australia (Denticare), for universal access to preventive and restorative dental care, and dentures, regardless of people’s ability to pay.

For a full list of reform directions under the theme of ‘Facing inequality’, see the appendix to this research paper. Following is commentary on each of the main areas discussed in the ‘Facing inequality’ section of the interim report, which focuses particularly on the most significant proposal for structural change, the universal dental health scheme, Denticare Australia.

Closing the health gap for Aboriginal and Torres Strait Islander peoples

The interim report’s ‘Closing the health gap for Aboriginal and Torres Strait Islander peoples’ chapter provides an overview of statistical discrepancies, central issues and recent initiatives. Despite several successful recent initiatives (for example, the PBS Section 100 arrangements to supply medicines to Indigenous people living in remote areas), the interim report presents evidence that ‘health care services for Aboriginal and Torres Strait Islander people are under-resourced’ and that services are delivered ‘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'.⁶⁶

The interim report makes a number of proposals for reform, the most significant of which is probably 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.⁶⁷

The interim report does not, however, offer a thorough or uniformly compelling analysis of how this proposed reform would work and improve on current arrangements. It is argued that while the 'Commonwealth Government's Department of Health and Ageing would still have overall responsibility for Aboriginal and Torres Strait Islander health':

... 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 ...

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.⁶⁸

There is no explanation of how this Authority will necessarily offer more efficient or stringent contractual arrangements and quality assurance than the Office of Aboriginal and Torres Strait Islander Health, how Indigenous people might be identified for registration purposes and how the Veterans' Affairs model might be applicable.

The Department of Veterans' Affairs provides health care and health servicing programs. However, the Veterans' Home Care program is effectively the same as the Department of

66. NHHRC, *A healthier future for all Australians: interim report*, pp. 207, 211.

67. NHHRC, *A healthier future for all Australians: interim report*, p. 198.

68. NHHRC, *A healthier future for all Australians: interim report*, p. 217.

Health and Aged Care's Home and Community Care program, and the justification for their separate administration for veterans has often been questioned. The interim report also does not explain how veteran-style health service entitlements would be an example of a practical, well-targeted solution to the most pressing Indigenous health service access problems.

Delivering better health outcomes for rural and remote communities

The interim report argues that many Australians in remote and rural areas do not have access to quality health care due to a number of factors, such as geographical isolation, lack of health services and a higher burden of disease.⁶⁹ It suggests that there is a need to 'build upon 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'.⁷⁰

Proposals for doing this include:

- flexible funding arrangements to facilitate locally designed and flexible models of care in remote and small rural communities
- better funding for the patient travel and accommodation assistance scheme and
- a higher proportion of new health professional educational undergraduate and postgraduate places across all disciplines be allocated to remote and rural regional centres.

Rural health groups such as the National Rural Health Alliance and the Rural Doctors Association of Australia (RDAA) have, on the whole, welcomed the reform directions proposed by the Commission.⁷¹ However, the RDAA has criticised the workforce measures in the interim report as inadequate to address what they argue is a 17 000 shortfall in health professionals in rural areas, including doctors, nurses and other health professionals. In the absence of a particular model of reform (including to one or another of the models outlined in the governance section of the interim report), it is difficult to comment further on issues related to the funding and governance of rural health.

69. NHHRC, *A healthier future for all Australians: interim report*, p. 227.

70. NHHRC, *A healthier future for all Australians: interim report*, p. 277.

71. National Rural Health Alliance, *Health Alliance backs needs-based funding for rural Australia*, media release, 16 February 2009, viewed 16 February 2009, <http://nrha.ruralhealth.org.au/cms/uploads/mediareleases/nhhrc%2016%20feb.pdf>; and Rural Doctors Association of Australia, *Health commission overlooks "priority number one" for rural health*, media release, 16 February 2009, viewed 16 February 2009, http://www.rdaa.com.au/uploaded_documents/ACF1EA9.pdf.

Supporting people living with mental illness

The interim report argues that current mental health services in Australia are ‘inadequate and incapable of meeting present, let alone future, needs’.⁷² Further, it states that while additional investment 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’.⁷³ The interim report sees these reforms as requiring two main approaches:

- targeting resources and efforts towards the most common mental health problems (for example, anxiety, depression and substance abuse disorders) and
- an emphasis on ‘stepped-up care’—that is, ‘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’.⁷⁴

These approaches are obviously consistent with the Government’s overall focus on prevention.

Probably the two most significant ‘key directions’ proposed by the Commission are:

- 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 and
- that the Early Psychosis Prevention and Intervention Centre (EPPIC) model be implemented nationally so that early intervention in psychosis becomes the norm.

In general, these proposals have been supported by mental health sector commentators on the grounds that they expand on existing approaches that have proven successful.⁷⁵

An important gap in the interim report is the lack of attention given to the role of primary care in addressing mental health.⁷⁶ Further, questions about which level of government and

72. NHHRC, *A healthier future for all Australians: interim report*, p. 247.

73. NHHRC, *A healthier future for all Australians: interim report*, p. 247.

74. NHHRC, *A healthier future for all Australians: interim report*, pp. 247–8.

75. See, for example, P McGorry, ‘Mental health reform needs urgent care’, *The Age*, 18 February 2009, viewed 19 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpre%2Fpre%2FY1TS6%22>; and S Rosenberg, ‘Crucial to fully support findings on mental health’, *The Canberra times*, 24 February 2009, viewed 25 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpre%2Fpre%2FG0VS6%22>.

which funding and governance structures should be ultimately responsible for mental health remain largely unanswered by the interim report. Given that one of the most frequent criticisms of Australia's mental health system relates to lack of clarity about responsibilities and the disjointed nature of care, this is an important issue. This may receive greater attention as the preferred governance model for the health system overall becomes clearer further down the track.

Improving oral health and access to dental care

The interim report rates the status of dental health in Australia as 'varied'.⁷⁷ Australia's ranking for adult tooth decay among OECD countries is in the lowest third and there is declining oral health among children.⁷⁸ Financial cost is a significant barrier to timely dental care, particularly for the most disadvantaged Australians. Around 20 per cent of the population neither has private health insurance nor uses private dental services, but instead relies on publicly funded means-tested dental services where waiting lists are long—up to 650 000 people are reportedly waiting for public dental care.⁷⁹

Until recently Commonwealth funding for dental care was very limited.⁸⁰ However, in recent years successive governments have expanded Commonwealth funding for dental services. The Howard Government introduced Medicare rebates for dental services for patients with chronic conditions where their health was being adversely affected by their dental problems. The Rudd Government has introduced the Teen Dental Plan and promised to introduce a Commonwealth Dental Health Program to assist the states and territories improve their public dental services, once the former Howard Government program is cancelled.⁸¹

76. L Russell, 'Health care report not quite what the doctor ordered', *The Canberra times*, 18 February 2009, viewed 19 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressclp%2FO7TS6%22>.

77. NHHRC, *A healthier future for all Australians: interim report*, pp. 261–2.

78. NHHRC, *A healthier future for all Australians: interim report*, pp. 261–2.

79. NHHRC, *A healthier future for all Australians: interim report*, p. 259.

80. For more details see: A Biggs, *Overview of Commonwealth involvement in funding dental care*, Research paper, no. 1, Parliamentary Library, Canberra, 2008–09, 13 August 2008, <http://www.aph.gov.au/Library/pubs/rp/2008-09/09rp01.pdf>.

81. Thus far, plans to cancel the program have been resisted in the Senate. See: A Biggs, *Dental benefits for chronic conditions: an update*, Background note, Parliamentary Library, Canberra, 30 October 2008, viewed 18 March 2009, http://www.aph.gov.au/Library/pubs/BN/2008-09/Dental_Benefits.htm.

Dental health services

The interim report makes six recommendations to improve access to dental health services. The most significant is the establishment and funding of a universal dental health insurance scheme, to be known as Denticare. The remaining recommendations concern the introduction of a one-year internship for newly graduated dentists to address workforce shortages, the expansion of existing school dental services and additional funding for improved oral health promotion.

Denticare Australia

Denticare would fund access to preventive and restorative dental care and dentures by a 0.75 per cent increase in the Medicare levy.⁸² People could choose either to join a private dental plan offered by health insurers or opt to use expanded free public dental services. Those choosing a private dental plan would have their risk-adjusted premiums paid by the Commonwealth.⁸³ The increase in the Medicare levy—estimated to raise around \$4 billion per annum⁸⁴—would be combined with other existing government dental expenditure, including the private health insurance rebate, to create a funding pool that would finance the scheme. The dental component of the initial cost of Denticare is estimated to be up to \$5.2 billion per annum, with direct government outlays representing an additional \$3.9 billion in spending over and above existing Commonwealth Government expenditure on dental health.⁸⁵

-
82. The Medicare levy is a 1.5 per cent tax on income that partially funds Medicare. In 2007–08, the Medicare levy raised \$8.049 billion, while Medicare ‘cost’ \$12.9 billion. See: Australian Government, *Final budget outcome 2007–08*, Commonwealth of Australia, Canberra, 2008, p. 3, viewed 6 March 2009, <http://www.budget.gov.au/2007-08/fbo/html/index.htm>; and Department of Health and Ageing (DHA) *Annual Report 2007–08*, Canberra, DHA, 2008, p. 76, viewed 6 March 2009, [http://www.health.gov.au/internet/main/publishing.nsf/Content/33F737C91421ADA0CA2574E3001D3470/\\$File/Full%20Report%20of%20the%202007-08%20Annual%20Report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/33F737C91421ADA0CA2574E3001D3470/$File/Full%20Report%20of%20the%202007-08%20Annual%20Report.pdf).
83. Premiums would be risk-adjusted, so they would be higher for those likely to require more dental services and lower for those likely to require less. See: NHHRC, *A healthier future for all Australians: interim report*, p. 268.
84. The interim report does not provide full costings. This estimate is based on the costings provided in a PriceWaterhouseCoopers report that was commissioned by the NHHRC to cost an insurance scheme for dental care. See: K Armstrong and M Campbell, *Costing a social insurance scheme for dental care*, PriceWaterhouseCoopers/NHHRC, 2008, p. 17, viewed 19 February 2009, [http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/\\$File/Costing%20a%20Social%20Insurance%20Scheme%20for%20Dental%20Care%20-%20November%202008.pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/$File/Costing%20a%20Social%20Insurance%20Scheme%20for%20Dental%20Care%20-%20November%202008.pdf).
85. Armstrong and Campbell, *Costing a social insurance scheme for dental care*, p. 16.

Those opting for the private dental plan would have 85 per cent of their dental costs reimbursed, with the option of purchasing additional health insurance for elective services, such as crowns and bridges. Funding for public dental services would be increased so that those without private health insurance would still have access to a free public dental service, albeit with waiting lists. The interim report estimates that under Denticare many would pay less for dental care, with those on low incomes set to benefit most. The supplementary consultant's report estimates that, for the average taxpayer, individual out-of-pocket costs for dental services would decrease from \$8.42 per week to \$3.98 per week.⁸⁶

Stakeholder and other responses

Thus far, responses to the Denticare proposal have been mixed. The Government has reserved its position, calling for public debate, although the Minister for Health has described Denticare as a 'fairly radical proposal'.⁸⁷ The Opposition's Shadow Minister for Health and Ageing, the Hon. Peter Dutton, has warned that 'taxpayers would pay billions of dollars in extra taxes', without directly condemning the proposal.⁸⁸ The Greens have welcomed the Denticare proposal and called on the Government to implement it 'as soon as possible'.⁸⁹

Stakeholder groups have also expressed a diverse range of views on the proposal. Significantly, the peak dental body, the Australian Dental Association (ADA), is strongly opposed to Denticare. It describes the proposal as 'fiscally irresponsible' and 'unlikely to deliver quality dental care', warning that the funding of such a scheme could be crippling and exceed \$11 billion.⁹⁰ On the other hand, Professor Hans Zoellner from the Association for the Promotion of Oral Health argues 'the Denticare proposal isn't as strong as it could be' and

86. Armstrong and Campbell, *Costing a social insurance scheme for dental care*, p. 24.

87. M Benson, 'Interview with Nicola Roxon', *ABC NewsRadio*, transcript, Australian Broadcasting Corporation, 16 February 2009, viewed 16 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22emms%2Fems%2F128685%22>.

88. P Dutton, *Denticare cost \$billions in new taxes*, media release, 16 February 2009, viewed 16 February 2009, <http://www.peterdutton.com.au/news/default.asp?action=article&ID=1096>.

89. Siewert, *Greens call for 'Denticare' – universal dental care*, media release, 16 February 2009, viewed 16 February 2009, <http://rachel-siewert.greensmps.org.au/content/media-release/greens-call-%E2%80%98denticare%E2%80%99-%E2%80%93-universal-dental-care>.

90. N Hewson, (Federal President, Australian Dental Association), *Australian Health and Hospitals Commission Report misses the mark on dental care*, media release, 16 February 2009, viewed 16 February 2009, http://www.ada.org.au/App_CmsLib/Media/Lib/0902/M156972_v1_633706483570330000.pdf

that a better solution is to ‘simply put dentistry in Medicare’, otherwise the scheme risks creating a ‘two tiered system’.⁹¹

Private health insurers are not agreed on the proposal. The Australian Health Insurance Association (AHIA) is still in the process of compiling a more considered response.⁹² Health insurer nib’s Chief Executive, Mark Fitzgibbon, has reportedly described Denticare as ‘inefficient and lack[ing] competition’, arguing ‘the Government should increase the private health care rebate for those who need it most’.⁹³

Other commentators have questioned the cost assumptions underpinning the proposal, warning these may be higher than those forecast.⁹⁴ Other concerns include: the limited capacity of the dental workforce to absorb the increase in demand for services, the bureaucratic complexity of the scheme, the possibility that it may entrench views that public dentistry is only for the poor, potential delays to the introduction of the Commonwealth Dental Health Program, and the entrenchment of inequity.⁹⁵

-
91. ‘Dental care plan ‘would create two-tiered system’’, *ABC news online*, transcript, Australian Broadcasting Corporation, 17 February 2009, viewed 17 February 2009, <http://au.news.yahoo.com/a/-/latest/5324990/dental-care-plan-create-twotiered/>.
 92. M Metherell, ‘Dentists lash out at free care plan’, *The Sydney morning herald*, 17 February 2008, viewed 17 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpre%2FPMSS6%22>.
 93. ‘Scrap Denticare, raise private health rebates: NIB’, *ABC news online*, transcript, Australian Broadcasting Corporation, 17 February 2009, viewed 18 March 2009, <http://www.abc.net.au/news/stories/2009/02/17/2493749.htm>.
 94. Lesley Russell from the Menzies Centre for Health Policy has estimated that the annual cost of the scheme could reach several billion dollars. See: L Russell, ‘Health care report not quite what the doctor ordered’, *The Canberra times*, 18 February 2009, p. 19, viewed 19 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpre%2FOTTS6%22>.
 95. Professor Hans Zoellner quoted in: A Cresswell, ‘Dental scheme targets the poor’, *The Australian*, 17 February 2009, viewed 17 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpre%2F4SSS6%22> ; Australian Healthcare and Hospitals Association, *Denticare must not delay election promises*, media release, 19 February 2009, viewed 19 February 2009, http://www.aushealthcare.com.au/news/news_details.asp?nid=13221&ao=s; and ‘Reform Alliance responds to Health Commission report’, *AHHA e-health care brief*, 24 February 2009, viewed 18 March 2009, https://promo-manager.server-secure.com/em/mail/view.php?id=275717682&k=590677a#Paragraph_11.

Costs and benefits

The potential cost of the Denticare proposal remains an issue of concern. Whether an increase of 0.75 per cent to the levy would be sufficient to wholly fund the additional cost of Denticare remains to be seen.⁹⁶ If the uncapped costs of Denticare were to exceed estimates, as is forecast by some commentators, these costs would need to be met through general revenue (possibly at the expense of other health funding), increased taxation or further increases to the Medicare levy. Further, any proposal to increase the Medicare levy almost inevitably leads to calls for further increases to fund other health services.⁹⁷

While taxpayers might support higher taxes for the provision of better health services, it is unclear if they would support a proposal such as this at a time of economic downturn, or if the benefits were to be unequally accessed. While the main beneficiaries would be those on lower incomes, it is not clear if other income groups would realise an immediate lowering of their costs for dental care.⁹⁸

The current dental workforce, particularly in the public sector, would be insufficient to meet the expected increase in demand for dental services if Denticare were to be introduced. It is therefore likely that a phased introduction of Denticare would need to be considered, possibly resulting in some taxpayers having to wait to become eligible for the scheme.⁹⁹

It is unclear how private health insurers would be affected by the proposal to part-fund the scheme through the reallocation of the private health insurance rebate. It is likely that there would be concerns that it may erode the dental component of private health insurance membership.¹⁰⁰ The interim report proposes that the proportion of the rebate which currently subsidises dental care be reallocated to help pay for Denticare. But how this could be achieved without undermining incentives to purchase private health insurance is not addressed. Broader questions about how increasing the Medicare levy ‘wipes out the next

96. It should be borne in mind that the Medicare levy only partially funds medical services; the balance is funded through general revenue.

97. Some have recently proposed an increase in the levy to fund lifelong disability. See: A Horin, ‘Official calls for disabled care levy’, *The Sydney morning herald*, 19 February 2009, viewed 19 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressclp%2F8ETS6%22>.

98. M. Wade, ‘Services not tax cuts, say voters’, *The Sydney morning herald*, 3 May 2004, p. 1, viewed 20 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressclp%2FX0DC6%22>.

99. Armstrong and M Campbell, *Costing a social insurance scheme for dental care*, p. 32.

100. Armstrong and Campbell, *Costing a social insurance scheme for dental care*, p. 34. On the flip side, ‘price reductions in private health insurance could make private health insurance more attractive’.

round of tax cuts’ and threatens to counteract other Government consumer spending initiatives, are likely to be of concern.¹⁰¹

Concluding comments

Overall, the interim report makes a strong case for greater equity in access to dental care and increased Commonwealth involvement in funding dental care based on the considerable support for greater funding and commitment to addressing oral health inequities. The proposed Denticare scheme is a complex proposal that has generated divided opinions. In their final report, the Commission may yet provide more detail and address some of the concerns raised.

Driving quality performance

The ‘Driving quality performance’ section of the interim report considers the better use of people, resources and evolving knowledge in the health system. Specifically, it examines issues relating to governance, priority setting, the health workforce and integrating research and innovation into the health system.

The following discussion focuses on proposed reforms to the funding and governance of the health system because of their significance to the overall reform agenda. Consideration is also given to the proposals regarding health workforce.

Funding

The interim report makes it clear that it supports the current mix of public and private financing in Australia, but it acknowledges that high out-of-pocket costs (co-payments) in some areas are a significant problem for many Australians. Rather than proposing changes to existing safety net arrangements such as the Medicare and PBS Safety Nets, the interim report concentrates on new proposals for allocating funding that aim to contain the costs of health care in the Australian health system. It makes three recommendations:

- Greater use of activity-based funding for hospitals where payments are made based on the number of services provided. Activity-based funding is thought to have benefits because it is transparent and fair, encourages development of more cost effective treatment pathways and encourages expansion into areas of high need. The risks are that some providers, however, may skimp on quality or shift costs onto other providers in order to reduce their own costs.

101. G Megalogenis, ‘Strife for PM if voters grind teeth over tax cuts devoured’ *The Australian*, 17 February 2009, viewed 17 February, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressclp%2F2SSS6%22>.

- Introducing ‘pay for performance’ (P4P) measures for all health services that achieve specified targets or goals. P4P has only recently been introduced in Australia in Queensland public hospitals and no data on its effectiveness are available yet. Internationally, there have been very few rigorous evaluations of P4P measures and results are mixed. There are some concerns that the costs of implementing P4P may outweigh the benefits if small-scale programs are rolled out, and ‘gaming’ by health professionals to select the healthiest patients is also a potential risk.¹⁰²
- Increased use of ‘course of care’ funding for primary care, which is a type of capitation funding. Under this system, payments are made according to the number of consumers (or patients) cared for over a period of time. They are used in Health Maintenance Organizations in the United States, Primary Health Organisations in New Zealand, and Primary Care Trusts in the United Kingdom. Course of care funding shares some of the same benefits and risks as activity-based funding but also encourages delivery of more integrated care—as providers are paid to deliver all necessary care to a patient (for example, all maternity care)—and allows consumers a greater choice of providers.

Governance

The Commission also tackles the controversial issue of health system governance, or who should run the health system. The interim report identifies a wide range of areas that would benefit from national leadership (including safety and quality of health care, clinical education and training, Indigenous health and regulation of private hospitals) and several alternative governance models.

Stakeholder views on health system governance vary widely and, given this lack of consensus and the complexity of the issue, the Commission chose to outline three alternative governance options (Options A, B and C) in an effort to stimulate debate. Some governance proposals put to the Commission, however, were not considered (for example, the case for a single national insurer) and the interim report does not comment on how it made its selection. Nor does it discuss how any of the options proposed would mesh with the Government’s previous ‘threat’ to take over hospitals. In the lead-up to the 2007 election, Labor stated that, if elected, it would take over public hospitals if the states and territories were unable to meet performance benchmarks by mid 2009, and if there was a public mandate to do so.¹⁰³ The

102. A Mehrotra, CL Damberg, MES Sorbero and SS Teleki, ‘Pay for performance in the hospital setting: what is the state of the evidence’, *American journal of medical quality*, vol. 24, no. 1, 2009, pp. 19–28; PK Lindenauer, D Remus, S Roman and MB Rothberg, ‘Public reporting and pay for performance in hospital quality improvement’, *New England journal of medicine*, vol. 356, no. 5, 2007, pp. 486–96; MB Rosenthal and RG Frank, ‘What is the empirical basis for paying for quality in health care’, *Medical care research and review*, vol. 63, no. 2, 2006, pp. 135–57.

103. See: ‘Federal hospital takeover’ *The Sydney morning herald*, 30 January 2009, p.1, viewed 30 January 2009,

Commission has made no attempt in the interim report to address any of the possible constitutional implications, particularly concerning options B and C.

Many stakeholders have expressed disappointment that the Commission—in accordance with its terms of reference—has not addressed perceived problems with the relationship between the public and private sectors. Many are concerned in particular about preserving the rebate on private health insurance premiums. Ian McAuley, from the University of Canberra, claimed the interim report entrenches vested financial interests in the health insurance industry.¹⁰⁴ The President of the Doctors Reform Society, Dr Tim Woodruff, questioned the Commission’s commitment to equity and efficiency because it ignored the implications of the private health insurance rebate.¹⁰⁵ The chief executive of the nib health fund, Mark Fitzgibbon, was just as concerned, but for different reasons. He argued that the current mix of public and private funding was unsustainable so the balance would have to tip back towards the private sector in order to meet the growing costs of health care.¹⁰⁶

The three options put forward by the Commission are considered briefly below.

Option A – Continuing shared state-federal responsibility

Under this model, the responsibilities of the Commonwealth and state and territory Governments would be re-aligned. The Commonwealth would assume all funding, policy and regulatory responsibility for primary health care and community health services. It would also pay the states and territories an activity-based payment for providing hospital care. The health system would be governed by a National Health Strategy and underpinned by eight bilateral agreements between the Commonwealth and each state and territory, much like current arrangements.

<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpre%2FJNS6%22>.

104. K Davidson, ‘Health report skips over our real ills’, *The Age*, 19 February 2009, viewed 20 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpre%2F4HTS6%22>.
105. K Davidson, ‘Health report skips over our real ills’, *The Age*, 19 February 2009, viewed 20 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpre%2F4HTS6%22>.
106. J Breusch, ‘Calls to revamp health-care funding’, *The Australian financial review*, 18 February 2009, viewed 18 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpre%2FK7TS6%22>.

While this model preserves many of the elements of the current system, there are some important changes in hospital funding. The Commonwealth hospital benefit would be predetermined (for example, at 40 per cent of the efficient cost of inpatient or emergency department treatment) and paid per episode of care. The Commonwealth's total expenditure, however, would be uncapped. The states and territories would be responsible for funding the remainder of the hospital benefit and would ultimately determine the limits of expenditure.

One of the claimed benefits of this model is that it involves less disruption to existing roles and responsibilities in health than the other models proposed, and means that state and territory governments continue to be accountable for their own health services. The model may also facilitate the integration of services because the Commonwealth would be responsible for all non-admitted care and have shared responsibility for inpatient hospital care. Continuing to involve two levels of government, however, may not resolve longstanding challenges and tensions when coordinating policies and programs, also known as the 'blame game'.

Option B – Commonwealth takeover of health

Under this model, the Commonwealth Government would assume all funding, policy and regulatory responsibility for health, and establish regional health authorities to deliver health services. National programs such as the MBS and PBS would run in parallel, and private health insurance arrangements would not necessarily need to be altered.

The Commonwealth would determine annual budgets for regional health authorities using activity-based funding methods. Budgets would be allocated for three-year periods so that regional health authorities could plan, commission and operate integrated health services within their region. This may involve linkages with the private and not-for-profit sectors.

The claimed benefits of this model are that it would substantially resolve the 'blame-game' between different levels of government and allow for more integrated and locally relevant care at the regional level. The main risks are that it would create tensions between the Commonwealth Government and regional health authorities, and require a major shift of funds and management expertise from the state and territory level. Making the Commonwealth solely responsible for health may reduce electoral accountability (as only one minister would be responsible for health) and regional health authorities, which would have considerable power at the local level, may be vulnerable to 'capture' or undue influence from major health services providers.

Option C – Social insurance

This option would involve transferring all responsibility for health to the Commonwealth government and establishing a tax-funded, compulsory community insurance scheme with a range of multiple, competing health plans or funds. Most plans would be privately owned and operated, but it would also be possible to have a government-owned and operated plan.

In this model, the Commonwealth Government allocates funding to health plans according to the risk-adjusted profile of their membership, and health plans would be required to provide the full range of health services determined by the Commonwealth. Health services would charge people directly and health plans would reimburse them for the cost of care. Co-payment levels could be set at the national level.

The principal claimed benefit of this model is that consumers would be able to choose the health plan that best met their needs. Health plans would then have incentives to be responsive to the needs of members. They would also have incentives to encourage health promotion and disease prevention, and ensure delivery of integrated, high quality and cost-effective care as this would potentially lower their costs. This model would, however, require large-scale changes to the health system and consumers may find it difficult to assess the merits of various health plans. Economies of scale achieved by having a compulsory tax-funded insurer (Medicare) would also potentially be lost and containing health costs may become an ongoing challenge as has been the case in other countries with similar systems (for example, Germany and France).¹⁰⁷

Discussion

There is widespread consensus about the need for reforms to the Australian health system but many divergent views on the scope and direction of reform. The interim report proposes a number of changes to the way health care is funded and governed in Australia and invites public debate on the issues. It is not clear what the Commission will recommend in its final report or, most importantly, how the Government will respond.

When considering governance options, the Government may respond, for instance, by prioritising what is politically possible. It may choose a new governance model according to how well it aligns with the underlying principles of Australia's health system. Alternatively, it may choose a governance model that is most likely to solve persistent problems in the health system. This, of course, raises questions about which problems should be considered as priorities.

Of the three governance models, Option A is the least radical and could be achieved by implementing small-scale incremental reforms to the current health system. The AMA, one of the most powerful stakeholders in the health system, has stopped short of advocating any model in particular, but its support for Option A can be assumed from its media statements. In a media release, the AMA stated that it saw 'no value to the community ... in pursuing some of the tired policies of budget-holding and restrictions on patient choice and rationing

107. S Grosse-Tebbe and J Figueras, eds, *Snapshots of health systems*, European Observatory on Health Systems and Policies, London, 2005, viewed 18 March 2009, <http://www.euro.who.int/document/e87303.pdf>.

that have failed patients in the United Kingdom'.¹⁰⁸ Budget-holding is a feature of both Options B and C.

The Government will find it easier to pursue its reform agenda with the AMA onside but this does not necessarily mean it will choose Option A. Many other stakeholders and commentators are urging the Government to seize the rare opportunity for reform and implement one of the 'big bang' reform proposals, Option B or C. Andrew Podger, former Secretary of the Commonwealth Department of Health and Ageing, argues that if the Government is prepared to do what is required to implement Option A, it might as well go the rest of the way and do what is needed to implement more radical reforms.¹⁰⁹ Professor Ian Hickie, Director of the Brain and Mind Medical Research Institute at the University of Sydney, argues that Option C—the social insurance model—is the only model that will allow 'serious attention [to] be devoted to the neglected areas of mental health care, treatments for alcohol and substance abuse or effective long-term health care plans for other neglected conditions'.¹¹⁰ Various other stakeholders, such as the Australian General Practice Network and the Australian Health Care Reform Alliance, also favour making substantial reforms to the existing health system.¹¹¹

The Government may choose to take what appears to be a less politically sensitive approach to reform and push for a governance model that aligns with the 15 principles for Australia's health system previously outlined by the Commission.¹¹² The interim report does not provide sufficient detail on the three governance proposals to allow an assessment of how well each of them is likely to align with these principles and thus it is difficult to predict how each model will operate in the Australian context. Any attempt to predict the proposed model's

108. Australian Medical Association (AMA), *AMA statement on the interim NHHRC report*, media release, 16 February 2009, viewed 16 February 2009, <http://www.ama.com.au/node/4480>.

109. A Podger, 'Australia must grasp the nettle of health reform', *The Australian financial review*, 4 March 2009, viewed 4 March 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressclp%2FLKXS6%22>.

110. I Hickie, 'Only one health option will work', *The Sydney morning herald*, 27 February 2009, viewed 27 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressclp%2FT1WS6%22>.

111. For example, see: Australian General Practice Network, *Radical change to Australia's health system is long overdue*, media release, 15 February 2009, viewed 11 March 2009, http://www.agpn.com.au/client_images/262360.pdf; and F Armstrong, 'Hospitals hardly rate a mention', *The Australian*, 21 February 2009, viewed 23 February 2009, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressclp%2F4BUS6%22>.

112. NHHRC, *Beyond the blame game: accountability and performance benchmarks for the next Australian Health Care Agreements: a report from the National Health and Hospitals Reform Commission*.

operation is likely to deliver highly contestable outcomes, forcing the Government to take a strong stand in order to pursue its reform agenda.

Alternatively, the Government may take a problem-solving approach to choosing a new governance model where it evaluates each model according to how well it solves persistent problems in the health system. It has already identified a range of problems—public hospital waiting lists, Indigenous health and a lack of emphasis on prevention. The problem-solving approach, however, is also likely to be complex from the perspective of Government. It will mean the Government will have to prioritise some problems in the health system over others, a move that is bound to invite criticism from advocates and interest groups whose causes and issues might be given less priority.

In the past, most major health system reforms in Australia have been pragmatic responses to emerging policy problems in health and the broader social, economic and political environment. Medicare, for instance, was implemented in Australia by the Hawke Government in 1984 because it helped solve the growing problem of un-insurance in Australia and secure the Accord with the Australian Council of Trade Unions. The Government was willing to bear the substantial increase in Government expenditure that came with implementing Medicare because union co-operation was so vital to its economic recovery plan.¹¹³

It is impossible at this stage to predict which governance model will be put forward by the Commission or how the Rudd Government might respond. If history is any guide, the Rudd Government, like its predecessors, is likely to respond in a way that balances its health, social, economic and political goals. While this is bound to disappoint many, significant reform of Australia's health system is necessary and, in the process of reform, a certain amount of controversy and resistance is inevitable.

Workforce issues

Shortages in the health workforce first began to surface as an issue in the mid 1990s when it was realised that there was no longer an adequate supply of medical practitioners, at least in rural and remote areas of Australia. Since the 1990s it has become increasingly clear that the case of medical practitioners is not isolated; there are shortages across the health professions.¹¹⁴ These shortages will be compounded as changes in the composition of the health workforce, noted by the Productivity Commission in 2005, manifest themselves. These changes are likely to include reduction in the hours health professionals work, the ageing of

113. A Boxall, 'Resolving tension: the development of Australia's health insurance system', PhD thesis, University of Sydney, 2008.

114. AIHW, *Australia's Health* 2008, p. 431.

the workforce and the feminisation of some previously male-dominated professions.¹¹⁵ The fact that shortages are not confined to Australia has provided an added dimension to this problem, given Australia's reliance on overseas trained professionals, particularly medical practitioners.¹¹⁶

The interim report restates these issues as well as raising other issues, such as the difficulties in delivering health services to rural and remote communities, as a prelude to identifying the Commission's 'case for change'.

Proposed health workforce reforms

The interim report points out that many see health workforce issues as being the major problem facing Australia's health system. Changes to the health system which involve one stop shops for primary health services or better care in hospitals will not be realised if the right health workforce is not available to deliver them.

Professor Peter Brooks, Executive Dean of Faculty of Health Sciences at the University of Queensland and Dr Stephen Duckett, former Chief Executive Officer of the Centre for Healthcare at Queensland Health,¹¹⁷ along with others, have consistently argued that workforce planning needs to take different directions and focus on different models than in the past, and that health system reform is dependent on these fundamental moves.¹¹⁸

The interim report does state clearly that because our health workforce resource pool is shrinking, we must think of new ways to make better use of people, resources and evolving

115. Productivity Commission, *Australia's health workforce*, Research report, Productivity Commission, Canberra, 2005, viewed 20 February 2009, http://www.pc.gov.au/data/assets/pdf_file/0003/9480/healthworkforce.pdf.

116. World Health Organization (WHO), *The world health report 2006: working together for health*, WHO, Geneva, 2006, viewed 20 February 2009, <http://www.who.int/whr/2006/en/index.html>. The report states that over the next decade there will be a shortage of over four million health workers.

117. Professor Peter Brooks is Executive Dean, Faculty of Health Services, University of Queensland, and Dr Stephen Duckett is Chief Executive Officer, Centre for Healthcare, Queensland Health.

118. For example, see: S Duckett, 'Health workforce design for the 21st century', *Australian health review*, vol. 29, no. 2, May 2005, pp. 201–10, viewed 20 February 2009, http://www.aushealthreview.com.au/publications/articles/issues/ahr_29_2_0505/ahr_29_2_201-210.asp; S Duckett, 'Next steps in health workforce reform', *Australian economic review*, vol. 13, no. 2, 2006, pp. 318–22, viewed 20 February 2009, <http://search.informit.com.au/fullText;dn=200611069;res=APAFT>; and P Brooks, 'The health workforce of the future—partnerships in health care', *Australian health consumer*, no.2, 2005–2006, viewed 20 February 2009, http://www.chf.org.au/Docs/Downloads/AHC2005-2_Brooks.pdf.

knowledge in the future. The central aspects in this challenge are related to delivering an adequate and appropriate workforce. While it begins to consider ways in which the challenge can be addressed it does not go far in exploring options, nor does it present innovative reforms where health workforce related issues are concerned. It may be that more in depth options and exploration of those options will be presented in the Commission's final report.

The interim report has gone some way towards acknowledging that simply increasing student numbers in the health professions does not constitute a comprehensive solution to health workforce shortages. There needs to be a structured and comprehensive approach to health workforce training that again is hinted at in broad terms in the interim report in words like 'flexible' and 'multi-disciplinary'. But it needs to be stated emphatically that this should reflect an overarching strategy that encompasses a cohesive health workforce, not a number of disconnected workforces. What currently exists, however, often reflects vested interests and traditional assessments of skill sets required for individual professions.¹¹⁹ Nor does current training accommodate, as noted above, factors such as the different attitudes future practitioners may have or changes in the composition of certain sectors of the workforce and the consequences those changes will have for workforce outcomes.

The interim report recognises that the current system of 'siloed' education is problematic. But how this can be addressed is not explored. This is important, for the lack of mutual respect and recognition among the various health workforces is often a major reason for professional dissatisfaction and people leaving some professions.¹²⁰ It is encouraging also that the issue of clinical training is raised, but discouraging that it is mainly considered in the context of medical practitioners and little consideration given to other medical professions.

The interim report's positive approach to the issue of workforce diversification, what some detractors have called 'task substitution' and what the interim report labels again as flexibility, is one of its strengths.¹²¹ The options noted, while brief, emphasise the interim report's conclusion: there are 'enormous possibilities' to be explored, perhaps one of the most

119. For example, some medical colleges, notably the Royal Australian College of Surgeons, have been accused of deliberately restricting entry to specialist courses. See: A Fels and F Brenchley, 'An unhealthy monopoly', *The Australian financial review*, 20 September 2005, viewed 2 March 2009,

<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressclp%2FSFCH6%22>. It is also argued that nurse practitioners do not have the necessary diagnostic and training skill sets to be allowed to augment the care they provide through access even to limited prescribing rights. See: 'General practice nurses good for health', *GP Network news*, issue 5, no. 13, 8 April 2005, viewed 2 March 2009, <http://www.ama.com.au/node/3928>.

120. The interim report makes this point in relation to nurses and allied health professionals. See NHHRC, *A healthier future for all Australians: interim report*, p. 323.

121. C Yong, 'Task substitution: the view of the Australian Medical Association', *Medical journal of Australia*, vol.185, no.1, viewed 23 February 2009, http://www.mja.com.au/public/issues/185_01_030706/yon10552_fm.html.

pressing tasks to be allocated to the proposed National Clinical Education and Training Agency.

Listing possible tasks for a National Clinical Education and Training Agency, which include advising on the adequacy of health workforce education and seeking innovative ways of delivering initial and ongoing skill sets, has the potential to deliver a radically evolved health workforce training model—sustainable and reflective of future needs. At the same time, appending the idea of innovation to the establishment of yet another health advisory/regulatory body could mean that innovation is stifled. It could be simply lost in the innate conservatism of bureaucracy or swamped by the usual outbreak of ‘turf’ wars which occur when health professions perceive their traditional roles and/or power are threatened.¹²² It will be a challenge in itself to develop a model for an agency that will not succumb to these pitfalls and even more of a challenge to ensure that it actually delivers the types of reforms suggested in the interim report.

The recent realisation that workforce shortages are not confined to ‘the bush’ has not deterred the Commission from paying considerable attention to rural and remote as well as Aboriginal and Torres Strait Islander health. The interim report recognises that overall measures to improve the health of Australians in the bush must emphasise rural models which can include greater emphasis on health promotion, early intervention and disease self-management. There has already been considerable innovation in workforce measures that encourage professionals to engage in rural practice,¹²³ but there is extensive potential to expand on measures such as remote area nurses, more specialist outreach services and expert health advice by telephone lines.

Submissions to the Commission emphasised that services in remote areas need to be based on uniquely rural models. Such models reflect the fact that medical practitioner services are often not available in rural communities. Encouraging more doctors to choose to practice in these areas through measures such as rural training is one solution, as the interim report acknowledges. But rural measures also need to involve the use of alternative practitioners to

122. Dr David Lindsay from James Cook University has alluded to an aspect of this—the medical profession’s objection to the nurse practitioners. See: ‘Doctor, nurse “turf war” hinders healthcare: academic’, *ABC news online*, 9 January 2009, viewed 16 March 2009, <http://www.abc.net.au/news/stories/2009/01/09/2462126.htm>.

123. For example, the establishment of rural clinical schools 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, as well as various other incentives for medical students and practitioners, such as the Bonded Medical Places Scheme and the Rural and Remote General Practice Program, which provide funding to improve the recruitment and retention of general practitioners in rural and remote areas. Other initiatives have also been introduced to encourage allied health professionals to practice in the bush. These include the establishment of a rural dental school at Charles Sturt University, a rural pharmacy workforce program and a continuing education program for rural nurses.

deliver services traditionally associated with the medical profession.¹²⁴ This, in turn, demands changes to funding models based on medical practitioners as service gatekeepers. The interim report's proposals support this innovation, with recommendations that, subject to regulation by appropriate medical bodies, scopes of practice could be extended.

Health outcomes for rural and remote areas could also be improved through greater use of information technologies. As the interim report notes, technology is an effective 'means to overcoming limited access to health care, the mal-distribution of health professionals and provision of expert advice in remote and rural areas'.¹²⁵ The interim report, however, did not identify more generally in this case for change the potential technology has to support the expertise of all health workers and to contribute to the desired sustainable workforce.

Stakeholder and other responses

It would be difficult to challenge conclusions about the health workforce made in the interim report. We do need to look at how we deal with pressures on the health workforce in terms of numbers, work practices and distribution, to build on what we have and there are problems within the existing system that inhibit change.

Many of the workforce recommendations in the interim report have been initially well received and are likely to continue to receive general support. The idea of a new education framework which stresses competency based standards, flexibility, multidisciplinary approaches and clinical infrastructure that stretches across public and private settings is hard to criticise. Aspects of this idea are not new and have been advanced elsewhere. For example, it is argued by a number of the health academics that medical practitioner shortages require a multi-dimensional strategy that needs to include the introduction of new health professionals to supplement the work of doctors in dealing with changing population health needs.¹²⁶ Some programs are already in place to accommodate a more expansive training regime for medical specialists, for example.¹²⁷ Similarly, competency based standards are essential assessment

124. R Jolly, *Health workforce: a case for physician assistants?*, Research paper, no. 24, Parliamentary Library, Canberra, 2007–08, viewed 18 March 2009, <http://www.aph.gov.au/library/pubs/rp/2007-08/08rp24.pdf>.

125. J Wakeman, J Humpreys, R Wells, P Kuipers, P Entwistle and J Jones, *A systematic review of primary health care delivery models in rural and remote Australia 1993–2006*, Australian Primary Health Care Research Institute, Canberra, 2006, viewed 23 February 2009, http://www.anu.edu.au/aphcri/Domain/RuralRemote/Final_25_Wakeman.pdf.

126. See: Jolly, *Health workforce: a case for physician assistants?*; as well as the extensive research in the American and international context undertaken by Dr Rod Hooker, including his recent collaborative work: L Frossard, G Liebich, R Hooker, P Brooks and L Robinson, 'Introducing physician assistants into new roles: International experiences', conference report, 35th Annual Physician Assistant Conference, Philadelphia, May 2007.

127. The Department of Health and Ageing funds an Expanded Specialist Training Program to this end.

components of nursing practice.¹²⁸ What is new and possibly contentious is the idea that the education system should, as the interim report puts it, ‘bridge the current siloed model of training’.

It is equally hard to criticise a proposal to involve health professionals in guiding the direction of health reform and promoting innovation. And, certainly, the idea of a national strategy to recruit and train Aboriginal and Torres Strait Islander health workers is long overdue. Getting all parties to agree on the extent to which some groups of health professionals should be involved in directing the health system is another matter; as is the issue of what ‘flexibility’ or ‘multidisciplinary’ might mean in various contexts.

The fundamental question on which there is most likely to be disagreement, however, is how the different health professions can work together to deliver a sustainable workforce. Indications are that initiating even the minimal changes to traditional roles that the interim report proposes will be resisted in some quarters and decried as inadequate in others. The AMA has consistently opposed other practitioners taking over what it sees as the exclusive role of doctors. The AMA has been opposed to extending Medicare access to other health professionals¹²⁹ and its comments on the interim report indicate that it has not changed its position.¹³⁰ Similarly, the Royal Australian College of General Practitioners criticises the interim report because it argues that it does not recognise the central role played by general practitioners in the health system.¹³¹ The Australian Nursing Federation, on the other hand, considers the interim report is not bold enough in its proposals for workforce and funding

128. For these standards, see: Australian Nursing and Midwifery Council website, *Professional standards*, viewed 2 March 2009, http://www.anmc.org.au/professional_standards/index.phphttp://www.anmc.org.au/professional_standards/index.php.

129. The Australian Medical Association (AMA) has stated: ‘The substitution of medical practitioners with other classes of health practitioner for workforce reasons or cost saving cannot be supported. No other class of health practitioner is sufficiently trained in the roles of medical practitioners to meet the health needs of the community’. AMA, *Health workforce reform*, media release, June 2008, viewed 23 February 2009, <http://www.ama.com.au/node/3306>.

130. AMA, *AMA statement on the NHHRC interim report*, media release, 16 February 2009, viewed 23 February 2009, <http://www.ama.com.au/node/4480>.

131. Royal Australian College of General Practitioners, *A healthy health system means access to general practice: College of GPs response to National Health and Hospitals Reform Commission report*, media release, 17 February 2009, viewed 23 February 2009, <http://www.racgp.org.au/media2009/30373>.

reform.¹³² These long-standing, polarised views are likely to pose ongoing challenges to health workforce reform.

Concluding comments

It may be that the greatest strength of the interim report is also its greatest weakness. In putting forward a bold, extensive document, in most areas it inevitably suffers from a lack of detail. The Commission should be commended for putting forward such a range of proposals; and it does explain that the interim report was designed to stimulate debate. What is perhaps lacking from the interim report is a single, focused and overarching blueprint for reform. Rather than a clear blueprint (or interim blueprint) for the future of the health system, the interim report tends to reflect the complex and sprawling nature of the system as it currently exists.

In reviewing the individual reform directions put forward by the Commission, it is clear that, if adopted to a significant degree, additional funding and dramatic increases in the health workforce will be required. The underlying theme of all the reform directions is greater Commonwealth responsibility and improved accountability, yet aspects of this may be contested by state, territory and local governments. The extent of Commonwealth responsibility for health will, however, ultimately depend on which governance model, if any, the Government adopts. The preferred option of the Commission will not be known until the final report is released.

Although the interim report notes that each of the reform directions can be implemented under any of the proposed governance models, it is not always clear how this could occur; for example, how the proposed arrangements for hospitals would work under Option C. This may be due, in part, to the lack of sufficient detail in the interim report to make an assessment about the governance models.

The lack of detail in some areas of the interim report raises several other unanswered questions, some of which may be addressed in the final report:

- what contribution could each of the governance models outlined in the ‘Driving quality performance’ section make to clarifying responsibilities and coordinating services in primary care, dental health and Denticare, hospitals, mental health, and Aboriginal and Torres Islander health?
- would the new focus on prevention give sufficient attention to primary prevention and public health—that is, the potentially more challenging instruments of prevention that reside outside of the health care system?

132. Australian Nursing Federation, *NHRC interim report makes good sense, but some barriers to health reform remain*, media release, 16 February 2009, viewed 23 February 2009, <http://www.anf.org.au/>.

- what would be the role of state and local governments in the provision of primary health care if the Commonwealth has full responsibility for primary care?
- given the Commission's focus on a strong public and private system, what role does the Commission envisage for private health funds in the provision of primary care?
- are the workforce reform proposals in the interim report capable of delivering the right numbers of professionals across the workforce but also deliver appropriate numbers of professionals in each of the professions and disciplines within those professions?

Again, these questions may be answered when the final report is released. What is clear, however, is that the interim report's release has generated a debate in health policy in Australia that is both more extensive and fundamental than has been seen for some time.

Appendix: list of reform directions

This is an extract from the interim report (pp. 29–42).

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

1.1 We affirm the value of universal entitlement to medical, pharmaceutical and public hospital services under Medicare which, together with choice and access through private health insurance, provides a robust framework for the Australian health care system. To promote greater equity, universal entitlement needs to be overlaid with targeting of health services to ensure that disadvantaged groups have the best opportunity for improved health outcomes.

1.2 We propose that public reporting on health status, health service use, and health outcomes by governments, private health insurers and individual health service providers identifies the impact on population groups who are likely to be disadvantaged in our communities.

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

1.4 We support the development of accessible information on the health of local communities. This information should take a broad view of the factors contributing to healthy communities, including the ‘wellness footprint’ of communities and issues such as urban planning, public transport, community connectedness, and a sustainable environment.

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

1.6 We propose that governments commit to establishing a rolling series of ten-year goals for health promotion and prevention, to be known as Healthy Australia Goals, commencing with Healthy Australia 2020 Goals. The goals should be developed to ensure broad community ownership and commitment, with regular reporting by governments on progress towards achieving better health outcomes under the ten-year goals.

1.7 We propose the establishment of an independent national health promotion and prevention agency. This agency would be responsible for national leadership on the ten-year health goals, as well as building the evidence base, capacity and infrastructure that is required so that prevention becomes the platform of healthy communities and is integrated into all aspects of our health care system.

1.8 We propose that the national health promotion and prevention agency would also collate and disseminate information about the efficacy and cost effectiveness of health promotion and prevention interventions.

1.9 We support strategies that help people take greater personal responsibility for improving their health through policies that ‘make healthy choices easy choices’. This includes individual and collective action to improve health by people, families, communities, health professionals, employers and governments.

1.10 We propose that health literacy is included as a core element of the National Curriculum and that it is incorporated in national skills assessment. This should apply across primary and secondary school.

1.11 We encourage all relevant groups (including health services, health professionals, non-government organisations, media, private health insurers and governments) to provide access to evidence-based, consumer-friendly information that supports people in making healthy choices and in better understanding and making decisions about their use of health services.

2. Creating strong primary health care services for everyone

2.1 We propose that, to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding.

2.2 We propose that, in its expanded role, the Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres.

2.3 We want young families and people with chronic and complex conditions (including people with a disability or a long-term mental illness) to have the option of enrolling with a single primary health care service to improve care. To support this, we propose that:

- There will be grant funding to support multidisciplinary clinical services and care coordination for that service tied to levels of enrolment of young families and people with chronic and complex conditions.
- There will be payments to reward good performance in outcomes including quality and timeliness of care for the enrolled population.
- Over the longer term, payments will be developed that bundle the total cost of care of enrolled individuals over a course of care or period of time, in preference to existing fee-based payments.

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

2.5 We support improving the way in which primary health care professionals and specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting. These arrangements should promote the vital role of primary health care professionals in the ongoing management and support of people with chronic and complex conditions.

2.6 We believe that service coordination and population health planning priorities could be enhanced at the local level through the establishment of Divisions of Primary Health Care, evolving from or replacing the existing Divisions of General Practice. These divisions will need to be of an appropriate size to provide efficient and effective coordination.

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

- Medicare rebates should apply to relevant diagnostic services and specialist medical services ordered or referred by nurse practitioners and other registered health professionals according to defined scopes of practice determined by health professional registration bodies.
- Pharmaceutical Benefits Scheme subsidies (or, where more appropriate, support for access to subsidised pharmaceuticals under section 100 of the *National Health Act 1953*) should apply to pharmaceuticals prescribed from approved formularies by nurse practitioners and other registered health professionals according to defined scopes of practice.
- Where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialed for defined scopes of practice.

2.8 In accordance with our later proposal for the establishment of a National Aboriginal and Torres Strait Islander Health Authority, we would expect that this Authority should be responsible for the purchasing of services that encourage and promote best practice and quality outcomes in primary health care for Aboriginal and Torres Strait Islander peoples wherever they elect to seek their health care.

2.9 We support the development of a person-controlled electronic personal health record. We will explore the prerequisites and incentives to allow us to reach this goal in our final report.

3. Nurturing a healthy start to life

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

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

- most importantly, a partnership with parents, supporting families – and extended families – in enhancing children’s health and wellbeing;
- a life course approach to understanding health needs at different stages of life, beginning with pre-conception, and covering the antenatal and early childhood period up to eight years of age. While the research shows that the first three years of life are particularly important for early development, we also note the importance of the period of the transition to primary school; and
- a child- and family-centred approach to shape the provision of health services around the health needs of children and their families. Under a ‘progressive universalism’ approach, there would be three levels of care: universal, targeted and intensive care.

3.3 We propose beginning the strategy for nurturing a healthy start to life before conception. Universal services would focus on effective health promotion to encourage good nutrition and healthy lifestyles, and on sexual and reproductive health services for young people. Targeted services would include ways to help teenage girls at risk of pregnancy.

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

3.5 We propose that universal child and family health services provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring (with contacts weighted towards the first three years of life). The initial contact would be universally offered as a home visit within the first two weeks following the birth. The schedule would include the core services of monitoring of child health, development and wellbeing; early identification of family risk and need; responding to identified needs; health promotion and disease prevention (for example, support for breastfeeding); and support for parenting.

3.6 We propose that, as part of its set of core services, where the universal child and family health services identify a health or developmental issue or support need, the service will provide or identify a pathway for targeted care, such as an enhanced schedule of contacts and referral to allied health and specialist services.

3.7 We propose that, where a child requires more intensive care for a disability or developmental concerns, a care coordinator, associated with a primary health care service, would be available to coordinate the range of services these families often need.

3.8 We propose that all primary schools have access to a school nurse for promoting and monitoring children's health, development and wellbeing, particularly through the important transition to primary school.

3.9 We propose that responsibility for nurturing a healthy start to life be embedded in primary health care to ensure continuity of care and a comprehensive understanding of a child's health needs. Families would have the opportunity to be enrolled with a primary health care service as this would enable well integrated and coordinated care and a comprehensive understanding of the health needs of a child and their family.

4. Ensuring timely access and safe care in hospitals

4.1 We propose development and adoption of National Access Guarantees for planned procedures and National Access Targets for emergency care. For example:

- a national access target for people requiring an acute mental health intervention (measured in hours);
- a national access guarantee for patients requiring coronary artery surgery or cancer treatment (measured in weeks/days); and
- a national access guarantee for patients requiring other planned surgery or procedures (measured in months).

These National Access Guarantees should be developed incorporating clinical, economic and community perspectives through vehicles like citizen juries.

Under the National Access Targets for emergency access, all hospital emergency departments should meet the triage access targets specified in *Beyond the Blame Game*, as well as additional measures of performance in promptly admitting people from emergency departments where they need it.

These National Access Targets operate at the level of individual hospitals.

4.2 A share of the funding potentially available to public hospitals should be linked to meeting (or improving performance towards) the access guarantees and targets, payable as a bonus.

4.3 We propose there be financial incentives to reward good performance in outcomes and timeliness of care. One element of this should be for timely provision of discharge information including details of any follow-up care required.

4.4 We support the use of activity-based funding for both public and private hospitals using casemix classifications (including the cost of capital).

- This approach should be used for inpatient and outpatient treatment.
- Emergency department services should be funded through a combination of fixed grants (to fund availability) and activity-based funding.
- The costs to hospitals with a major emergency load of having to maintain capacity to admit people promptly should be recognised in the funding arrangements.

4.5 We propose that all hospitals review provision of ambulatory services (outpatients) to ensure they are designed around patients' needs and, where possible, located in community settings.

4.6 To improve quality, data on quality and safety should be collated, compared and provided back to hospitals, clinical units and clinicians in a timely fashion to expedite quality and quality improvement cycles. Hospitals should also be required to report on their strategies to improve safety and quality of care and actions taken in response to identified safety issues.

4.7 To improve accountability, we propose that public and private hospitals be required to report publicly on performance against a national set of indicators which measure access, efficiency and quality of care provided.

4.8 We propose that public and private hospital episode data is collected nationally using a patient's Medicare card number to understand better people's use of health services and outcomes across different care settings.

4.9 We suggest that the future planning of hospitals should encourage greater delineation of hospital roles including separation of planned and emergency treatment, and optimise the provision and use of public and private hospital services.

4.10 We propose a nationally led, systemic approach to encouraging, supporting and harnessing clinical leadership within hospitals and broader health settings and across professional disciplines.

5. Restoring people to better health and independent living

5.1 We want to increase the visibility of, and access to, sub-acute services through more directly linking funding to the delivery and growth of sub-acute services. A priority focus should be the development of activity-based funding models for sub-acute services (including the cost of capital), supported by improvements in national data and definitions for sub-acute services.

5.2 We support a dual approach to funding of sub-acute services, comprising a mix of activity-based funding with the use of incentive payments related to improving outcomes for patients.

5.3 We propose that clear targets to increase provision of sub-acute services be introduced by June 2010. These targets should cover both inpatient and community-based services and should link the demand for sub-acute services to the expected flow of patients from acute services and other settings. Incentive funding under the National Partnership Payments could be used to drive this expansion in sub-acute services.

5.4 We propose that investment in sub-acute services infrastructure be one of the top priorities for the Health and Hospitals Infrastructure Fund.

5.5 We need to ensure that we have the right workforce available and trained to deliver the growing demand for sub-acute services including in the community. Accordingly, we support the need for better data on the size, skill mix and distribution of this workforce including rehabilitation medicine specialists, geriatricians and allied health staff.

5.6 We recognise the vital role of equipment, aids and other devices, in helping people to improve health functioning and to live as independently as possible in the community. Ensuring affordable access to such equipment will be considered under reform direction 13.4 that foreshadows further work on the development of integrated safety nets.

6. Increasing choice in aged care

6.1 We believe that funding should be more directly linked to people rather than places, and to those who are most likely to need care. We propose changing the limit on provision of aged care subsidies from places per 1000 people aged 70 or over to care recipients per 1000 people aged 85 or over.

6.2 We suggest that consideration be given to permitting accommodation bonds or alternative approaches as options for payment for accommodation for people entering high care, provided that removing regulated limits on the number of places has resulted in sufficient increased competition in supply and price.

6.3 We propose requiring aged care providers to make standardised information on service quality and quality of life publicly available on agedcareaustralia.gov.au to enable older people and their families to compare aged care providers.

6.4 We support consolidating aged care under the Commonwealth by making aged care under the Home and Community Care (HACC) program a direct Commonwealth program.

6.5 We propose developing and introducing streamlined, consistent assessment for eligibility for care across all aged care programs.

6.6 We propose that there be a more flexible range of care subsidies for people receiving community care packages, determined in a way that is compatible with care subsidies for residential care.

6.7 We propose that people who can contribute to the costs of their own care should contribute the same for care in the community as they would for residential care (not including accommodation costs).

6.8 We propose that people supported to receive care in the community should be given the option to determine how the resources allocated for their care and support are used.

6.9 We propose that once assessments, care subsidies and user payments are aligned across community care packages and residential care, older people should be given greater scope to choose for themselves between using their care subsidy for community or for residential care.

6.10 We propose that all aged care providers (community and residential) should be required to have staff trained in supporting care recipients to complete advanced care plans for those care recipients who wish to do so.

6.11 We propose that funding be provided for use by residential aged care providers to strike arrangements with primary care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes.

6.12 We propose:

- increased use of electronic clinical records in aged care homes, including capacity for electronic prescribing by attending medical practitioners, and providing a financial incentive for electronic transfer of clinical data between services and settings (general practitioners, hospital and aged care), subject to patient consent; and
- the hospital discharge referral incentive scheme (see Chapter 4) include timely provision of good information on a person's hospital care to the clinical staff of their aged care provider, subject to patient consent.

7. Caring for people at the end of life

7.1 We propose building the capacity and competence of primary health care services, including the Comprehensive Primary Health Care Centres proposed in Chapter 2, to provide generalist palliative care support for their dying patients. This will require greater educational support and improved collaboration and networking with specialist palliative care service providers.

7.2 We support strengthening access to specialist palliative care services for all relevant patients across a range of settings, with a special emphasis on people living in residential aged care facilities.

7.3 We propose that additional investment in specialist palliative care services be directed to support more availability of these services to people at home in the community.

7.4 We propose that funding be provided for the national implementation of the Respecting Patient Choices program (advance care planning) across all residential aged care services.

7.5 We support greater awareness and education among health professionals of the common law right of people to make decisions on their medical treatment, including the right to decline treatment. We note that, in some states and territories, this is complemented by supporting legislation that relates more specifically to end of life and advance care planning decisions.

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

8.1 We propose that the Commonwealth Department of Health and Ageing take a lead in the inter-sectoral collaboration that will be required at the national level to redress the impacts of the social determinants of health to close the gap for Aboriginal and Torres Strait Islander peoples.

8.2 We propose an investment strategy for Aboriginal and Torres Strait Islander Australians' health that is proportionate to health need, the cost of service delivery, and the achievement of desired outcomes. This requires a substantial increase on current expenditure.

8.3 We propose establishing a function to build and expand organisational capacity for Community Controlled Health Services to provide and broker comprehensive primary health care services. We would welcome feedback on the appropriate auspicing body or agency for such a support function.

8.4 We propose strengthening the purchasing role to lead the additional investment in Aboriginal and Torres Strait Islander health. This could be achieved by the establishment of a National Aboriginal and Torres Strait Islander Health Authority to purchase services specifically for Aboriginal and Torres Strait Islander Australians and their families as a mechanism for closing the gap. This Authority would purchase health services from accredited providers with a focus on outcomes to ensure high quality and timely access.

8.5 We propose that accreditation processes for health services and education providers incorporate, as core, specific Indigenous modules to ensure quality clinical and culturally appropriate services.

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

9. Delivering better health outcomes for remote and rural communities

9.1 Flexible funding arrangements are required to reconfigure health service delivery to achieve the best outcomes for the community. To facilitate locally designed and flexible models of care in remote and small rural communities, we propose:

- funding equivalent to national average medical benefits and primary health care service funding, appropriately adjusted for remoteness and health status, be made available for local service provision where populations are otherwise under-served; and
- expansion of the multi-purpose service model to towns with catchment populations of approximately 12,000.

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

- networks of primary health care services, including Aboriginal and Torres Strait Islander Community Controlled Services, within naturally defined regions;
- expansion of specialist outreach services – for example, medical specialists, midwives, allied health, pharmacy and dental/oral health services;
- telehealth services including practitioner-to-practitioner consultations, practitioner-to specialist consultations, teleradiology and other specialties and services;
- referral and advice networks for remote and rural practitioners that support and improve the quality of care, such as maternity care, chronic and complex disease care planning and review, chronic wound management, and palliative care; and
- ‘on-call’ 24-hour telephone and internet consultations and advice, and retrieval services for urgent consultations staffed by remote medical practitioners.

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

9.3 We propose that a patient travel and accommodation assistance scheme be funded at a level that takes better account of the out-of-pocket costs of patients and their families and facilitates timely treatment and care.

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

10. Supporting people living with mental illness

10.1 We propose that a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service.

10.2 We propose that the Early Psychosis Prevention and Intervention Centre model be implemented nationally so that early intervention in psychosis becomes the norm.

10.3 We believe that every acute mental health service should have a rapid-response outreach team for those individuals experiencing psychosis.

10.4 We propose that every hospital-based mental health service should be linked with a multi-disciplinary community-based sub-acute service that supports ‘stepped’ prevention and recovery care.

10.5 We strongly support greater investment in mental health competency training for the primary health care workforce, both undergraduate and postgraduate, and that this training be formally included as part of accreditation processes.

10.6 We propose that each state and territory government provide those suffering from severe mental illness with stable housing that is linked to support services.

10.7 We want governments to increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support.

10.8 As a matter of some urgency, governments must collaborate to develop a strategy for ensuring that older Australians, including those residing in aged care facilities, have adequate access to specialty mental health and dementia care services.

10.9 We propose that state and territory governments recognise the compulsory treatment orders of other Australian jurisdictions.

10.10 We propose that health professionals should take all reasonable steps in the interests of patient recovery and public safety to ensure that when a person is discharged from a mental health service that:

- there is clarity as to where the person will reside; and
- someone appropriate at that location is informed.

10.11 We propose a sustained national community awareness campaign to increase mental health literacy and reduce the stigma attached to mental illness.

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

11. Improving oral health and access to dental care

11.1 We propose that Australia should have a scheme ‘Denticare Australia’ for universal access to preventive and restorative dental care, and dentures, regardless of people’s ability to pay.

11.2 We propose that ‘Denticare Australia’ be based on a mixed approach of public and private cover. The additional costs would be funded by an increase in the Medicare Levy of 0.75 per cent of taxable income, with people opting either to become a member of a dental health plan (with a private insurer), or to use public dental services.

11.3 We support an equitable approach to financing a universal dental scheme. Under the proposed approach, the funding of dental services will be linked to ability to pay through an increase in the Medicare Levy. We estimate that under this approach:

- Many people will pay no more than they currently pay for dental care; the increase in Medicare Levy of 0.75 per cent of taxable income will be smaller than existing out-of-pocket costs for dental services for many people.

- People on low incomes will pay considerably less and have much better access to dental health services.

11.4 We support the introduction of a one-year internship scheme prior to full registration, so that clinical preparation of oral health practitioners (dentists, dental therapists and dental hygienists) operates under a similar model to medical practitioners.

11.5 We propose the national expansion of the pre-school and school dental programs.

11.6 We propose that additional funding be made available for improved oral health promotion, with interventions to be decided based upon relative cost effectiveness assessment.

12. Strengthening the governance of health and health care

12.1 We propose a range of functions that should be led and governed at the national level, including leadership for patient safety and quality (including service accreditation), health promotion and prevention, professional registration, workforce planning and education, performance reporting, private hospital regulation, and technology assessment.

12.2 We propose that the Commonwealth should take responsibility for policy and funding of all primary health care.

12.3 We propose to give further consideration to the following three options for reform of governance:

(A) Shared responsibility with clearer accountability. Retain both Commonwealth and state and territory involvement but re-align responsibilities between them, with the Commonwealth:

- becoming responsible for all primary health care funding and policy; Reform Directions 39
- 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.

© Copyright Commonwealth of Australia

This work is copyright. Except to the extent of uses permitted by the *Copyright Act 1968*, no person may reproduce or transmit any part of this work by any process without the prior written consent of the Parliamentary Librarian. This requirement does not apply to members of the Parliament of Australia acting in the course of their official duties.

This work has been prepared to support the work of the Australian Parliament using information available at the time of production. The views expressed do not reflect an official position of the Parliamentary Library, nor do they constitute professional legal opinion.

Feedback is welcome and may be provided to: web.library@aph.gov.au. Any concerns or complaints should be directed to the Parliamentary Librarian. Parliamentary Library staff are available to discuss the contents of publications with Senators and Members and their staff. To access this service, clients may contact the author or the Library's Central Entry Point for referral.
