

# NEXT STEPS IN AUSTRALIAN HEALTH REFORM

The proposals of the Victorian Premier

June 2008







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# PREMIER'S FOREWORD

Australia faces big challenges over the coming decades.

With the right policies, we can not only meet those challenges but also seize the opportunity to become one of the world's leading economies.

Victoria is acutely aware that the health of our citizens is pivotal to the future economic viability of our state.

Whilst Australians enjoy health outcomes that are amongst the best in the world and have access to high quality health care, there is considerable scope for improvement. The impact of disease on our society is substantial, with the most disadvantaged members of the community most likely to be affected. The fact that a large proportion of disease experienced is preventable demonstrates that much more needs to be done.

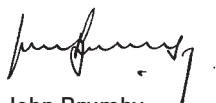
Reform in this area is long overdue. It is time for a once-in-a-generation change to the way in which we view and treat illness in our society. This report sets out the means for both short- and long-term progress towards new goals. Many proposals contained within this report could be agreed immediately by the Commonwealth and the States and Territories as part of the new national health care agreement. Other longer-term proposals for reform can be considered by the National Health and Hospitals Reform Commission.

In this report, my Government offers ideas about priority reforms which will ensure the good health of our citizens. These include calls for a more active approach to maintaining wellness, better support for people with chronic disease, and reforms to our workforce, information technology and funding systems to enable major change. While all Australian governments must lead the way in securing good health, in the end effective reform also depends on a shared commitment from business, the community and individuals.

*Next Steps in Australian Health Reform* calls on:

- › All governments to agree on a practical framework for national health reform, a timetable for transparent measurement of progress and accountability mechanisms to ensure delivery;
- › All sectors – government, community and private – to embrace the need for reform and commit new resources to investing in Australians' health; and
- › Individuals being supported to understand and take responsibility for their own health and wellbeing.

In the coming months, my Government will actively progress this reform agenda through COAG, Health Ministers and the National Health and Hospitals Reform Commission. The newly agreed Commonwealth-State financial arrangements provide an ideal opportunity to embed real reform in our system of health care. We value the input of the Australian community as we embark on this shared ambition to reform our health system for the future.

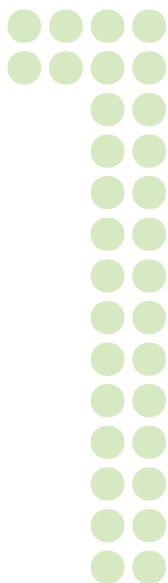


**John Brumby**  
Premier of Victoria



# TABLE OF CONTENTS

Overview	5
The National Health Reform Challenge	10
Keeping Australians Fit and Healthy	19
Providing the Right Care in the Community	28
Delivering High Quality Specialised Care	39
A Sustainable and Fair Health Care System for Australia	48
Implementing and Financing Health Reform	66
The Way Forward	69



# OVERVIEW

## 1.1 The National Health Reform Challenge

Australia's health system is at a crossroads. Significant and unprecedented challenges in meeting our nation's health needs are coming at a time of great economic prosperity. History will record this era as a time of unique opportunity for governments to take transformative action on health for all Australians.

While Australians enjoy health outcomes that are among the best in the world and have access to high quality health care, there is considerable scope for improvement. The burden of disease is substantial, and is much more likely to be borne by the most disadvantaged members of the community. The fact that a large part of the disease burden is preventable demonstrates that much more needs to be done.

The imperative to act on health reform is growing every day. New and existing pressures are challenging the health and wellbeing of individuals, and threatening the overall sustainability of the health care currently available to Australians. In addition to longstanding health inequalities among disadvantaged communities, our population is ageing, some diseases are becoming more prevalent, health care costs are rising, and the health workforce is already stretched to the limit. Unless action is taken, these pressures will combine to restrict access, lengthen waiting times, and raise health costs – which can only worsen Australians' health outcomes and increase the economic cost of ill health to the nation.

For many structural and historical reasons, our health care system is ill-equipped to adapt to these challenges. The fragmentation of the system – in particular the complex split in responsibilities of the Commonwealth and State Governments – imposes 'artificial and arbitrary boundaries on consumers and health care professionals who need to manage episodes of care in a flexible and coordinated manner'.<sup>1</sup> Funding arrangements do not encourage continuity of care, provision of multidisciplinary care, or provision of care in the most clinically appropriate setting. Tackling these factors requires comprehensive reform.

Notwithstanding the challenges, there are solid foundations from which to proceed. There is a strong appetite for significant reform across the health sector, governments and the community. All Australian governments have recognised the fundamental link between good health and increasing national workforce productivity and participation, and have committed to significant actions to invest in the nation's human capital. This commitment to national health reform was a feature of the March 2008 meeting of the Council of Australian Government (COAG).

This paper proposes a series of reforms – both immediate and medium-term – that can begin the transformation of our health system for the future. It is hoped that this paper can form the basis for negotiation and agreement by all Australian governments to move forward on implementing national health reform.

<sup>1</sup> AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS 2002, A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE, SEPTEMBER, P. 3, QUOTED IN ALLEN CONSULTING GROUP 2004, GOVERNMENTS WORKING TOGETHER: A BETTER FUTURE FOR ALL AUSTRALIANS, MELBOURNE.

## 1.2 The Reform Agenda

This paper starts with an understanding of the importance of good health to Australians and their communities. It aspires to look at our health care arrangements from the perspective of the needs of individuals, as well as from the perspective of governments. To this end, it puts forward an agenda for national health reform based on four goals for the health care that is available to all Australians (Figure 1).

FIGURE 1: GOALS FOR THE HEALTH OF ALL AUSTRALIANS

Goal 1	Goal 2	Goal 3	Goal 4
Australians are fit and healthy	Australians receive the right care in the community	Australians receive high quality specialised care	Australians have a sustainable and fair health system

Figure 2 illustrates the approach that is taken in this paper to identifying opportunities for reform that could help achieve these goals. For each of our four health care goals we have identified:

- › **Desired outcomes** that describe the goal in more detail, and allow measurement of progress in achieving the goal;
- › **Key challenges** that stand in the way of achieving the goal and desired outcomes;
- › **Reform directions** that set the vision and long-term agenda to achieve the desired outcomes; and
- › **Reform proposals:** specific proposals that will improve outcomes.

FIGURE 2: A FRAMEWORK FOR HEALTH REFORM



Health reform is a national issue that needs a national solution. The chapters that follow show that the challenges to achieving each goal are considerable, and the reforms that are needed are extensive.

Our federal system offers the best prospects for moving forward with national health reform in an efficient, productive and responsible way. We know from the success of National Competition Policy (NCP) just how well federalism can work. The 1995 agreement by all Australian governments to implement NCP was central to the economic reforms of the late 1990s, and demonstrates what can be achieved when governments work together for the wellbeing of all Australians.

The key factors for success of the NCP were:

- › an agenda agreed by all governments up-front outlining reform commitments;
- › independent monitoring and reporting on progress; and
- › the provision of performance and financial incentives for States to undertake reform.

Australians need their governments to bring that same collaborative spirit to the crucial task of reforming our nation's health system.

The reform proposals set out in this paper should be considered as an initial down-payment on a long-term program of reform. If rapidly implemented, these proposals could deliver better health care and health outcomes for all Australians. But they are not sufficient. To make real progress against the desired outcomes will require sustained activity by both the Commonwealth Government and the States and Territories. The reform directions under each goal set out the broader reform vision.

Box 1 sets out ten key proposals of the reform agenda for the short to medium term. The first nine proposals are opportunities for immediate action to improve Australians' health outcomes and their access to high quality health care. These reforms could be agreed at the earliest possible opportunity. The tenth proposal is for significant reform of health financing arrangements, which would need to be considered in further detail by the National Health and Hospitals Reform Commission (NH&HRC). Additional proposals for supporting reform, and other issues requiring further consideration are put forward in the following chapters.

In some cases, recent Commonwealth Government commitments are in substantial alignment with these proposals and already demonstrate a strong commitment to health reform. In others, the proposals are consistent with election commitments but take the debate further. All jurisdictions need to work together collaboratively to deliver on genuine and sustained reform.

## BOX 1: TEN KEY REFORM PROPOSALS

- › Roll out Victoria's Work Health plan across Australia, giving people access to preventative health support in their workplaces.
- › Establish sub-regional "Healthy Living Partnerships" across Australia, involving the Commonwealth, States, local government and other key partners, to strengthen and coordinate local efforts to keep people fit and healthy, as part of a new national approach to primary prevention.
- › Establish more integrated primary care 'super-clinics' in highest priority areas across Australia in ways that maximise the benefits to patient care and system performance, including by aligning with existing State funded services, using innovative service models and taking account of regional needs.
- › Enhance the level of public subsidy and public provision of dental services, particularly for those with most need.
- › Introduce a new funding mechanism for the Commonwealth to fully fund care for older Australians who have been Aged Care Assessment Team (ACAT) assessed and are waiting at home or in hospital for an aged care place.
- › Enhance the provision of dedicated elective surgery capacity to increase access and reduce delays, including through selective contracting of the private sector.
- › Improve capacity to train nurses, doctors and other health professionals in regional centres.
- › Request urgent advice about how to meet the immediate health workforce shortages of the next five years.
- › Commonwealth to immediately fund and fast-track the development and roll out of 21st century e-health standards and infrastructure required for shared electronic health records, in collaboration with States and Territories on implementation.
- › Further consideration of significant reform to health financing, in the context of a new national health care agreement, including:
  - a) A new activity-based funding approach to provide States and Territories with sustainable resources for public hospitals recognising the community obligations which public hospitals fulfil (e.g. training and rural provision), and providing incentives for efficient service delivery. No State or Territory would be disadvantaged over any transition period;
  - b) Establishment of a single, sustainable approach to indexation of Commonwealth hospital funding, covering the proposed activity-based funding approach and the relevant components of private health insurance premium increases;
  - c) More consistent funding arrangements across preventative health, primary, emergency departments, acute and aged care, which reduce distortions and create incentives for the efficient allocation of resources;
  - d) Ways to strengthen the role that private health insurance plays in improving health outcomes; and
  - e) In the longer term, regional funding models which would see each State or Territory providing for area-based decision-making on service 'commissioning' and investment priorities across preventative, primary and acute care, and interim regional approaches which may support a transition to this model.

### 1.3 Implementing Reform

As an equal partnership of Australian governments, the Council of Australian Governments (COAG) will be a key decision-making body and have a pivotal role in agreeing national reform proposals. Proposals will benefit from further consideration through COAG over the next 6 to 12 months, as the new national health agreement is negotiated and implemented. Health Ministers will have a central role to play in establishing the reform agenda and its successful implementation.

By mid-2009, we would expect the NH&HRC to have produced immediate and supporting reforms that are able to be agreed by all governments.

It is evident that action by governments alone will not be enough to achieve effective reform. We need to recognise that good health is a shared responsibility between individual Australians, communities, their governments, and health care providers. One priority for the NH&HRC should be to commence a national community engagement process that allows Australians to articulate what they want from their health care system, and discuss our individual responsibilities.

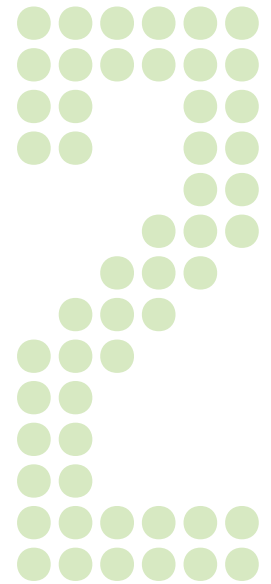
Immediate action on these first, important steps will ultimately give all players the time and necessary momentum to develop the longer-term action agenda for national reform. A key leadership body in this process will be the NH&HRC. However, we must be realistic about what a body like the NH&HRC can be expected to achieve in its timeframe. A critical role will be for the body to recommend the long-term mechanisms required to enable a process of ongoing, dynamic change in this complex sector.

### 1.4 This Report

This report outlines an agenda for national health reform that is both timely and achievable. We begin with a discussion of the challenges facing our health system, the urgent need for reform, and the strong foundations we have to move this agenda forward (Chapter 2).

In Chapters 3 to 6, we discuss the four goals for the health care that is available to Australians, and for each, identify desired outcomes, key challenges, existing government commitments, reform directions and detailed reform proposals.

In Chapters 7 and 8, we propose a practical agenda for implementing and financing health reform and discuss the next steps needed to progress this agenda.



# THE NATIONAL HEALTH REFORM CHALLENGE

## 2.1 Introduction

Giving all citizens access to the best quality health care and supporting them to maintain good health throughout life is a basic goal of every society. Communities and their governments aspire to a society in which as many people as possible can lead healthy and active lives. In addition, a healthy society is the foundation for the human capital that increasingly drives economic success: healthy, active people are more likely to participate in the workforce, and are also more productive. Action to improve public health, and to prevent and manage ill health will ensure that Australia is better equipped to withstand impending demographic changes and skills shortages.

The health and wellbeing of individuals is influenced by a multitude of political, economic, social, cultural, environmental, behavioural and biological factors (See Table 1). This means that our approach to promoting health and wellbeing must be sustained, comprehensive and holistic.

TABLE 1: DETERMINANTS OF HEALTH

Individual endowments	Personal circumstances	Societal factors
Biology and genetic endowment Gender Healthy child development	Income and social status Social support networks Education and literacy Employment/working conditions Personal health practices and coping skills	Culture Social environments Physical environments Health services

SOURCE: PUBLIC HEALTH AGENCY OF CANADA 2003, 'WHAT DETERMINES HEALTH?', [HTTP://WWW.PHAC-ASPC.GC.CA/PH-SP/PHDD/DETERMINANTS/DETERMINANTS.HTML](http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/determinants.html), ACCESSED 26 NOVEMBER 2007.

This chapter reviews the current Commonwealth and State and Territory roles and responsibilities for Australia's health system, and goes on to examine the long-term trends that are threatening the system's overall sustainability. Each following chapter will look at challenges specific to achieving each of the four goals.

## 2.2 Current Government Responsibilities

The Commonwealth and State and Territory governments share responsibility for the funding and delivery of health services. The split of roles and responsibilities is complex and blurred, causing overlap and duplication. This is one of the key challenges to the health system discussed in Chapter 6.

The responsibilities of the Commonwealth include:

- › jointly funding public hospitals with the States and Territories;
- › providing financial benefits for private medical services such as GPs through Medicare;
- › subsidising pharmaceuticals through the Pharmaceutical Benefits Schedule (PBS);
- › supporting private hospitals, through a tax rebate on private health insurance premiums;
- › funding some public health services; and
- › funding health research.

The responsibilities of State and Territory governments include:

- › jointly funding public hospitals with the Commonwealth Government;
- › planning and administration of the public hospital system;
- › funding community and public health services, including mental health programs; and
- › funding patient transport.

TABLE 2: COMMONWEALTH AND STATE AND TERRITORY ROLES AND RESPONSIBILITIES

Service type	Roles and funding arrangements
Public hospitals	<ul style="list-style-type: none"> <li>› Co-funded by the States and Territories and the Commonwealth under the AHCA.<sup>a</sup></li> <li>› States and Territories responsible for operating and regulating public hospitals within their jurisdictions.</li> </ul>
Private hospitals	<ul style="list-style-type: none"> <li>› Funded by health insurance funds and the Commonwealth, through private health insurance rebates and funding for services for eligible veterans and their dependants on a fee-for-service basis.</li> </ul>
Medical services	<ul style="list-style-type: none"> <li>› Most medical services are provided by GPs and medical specialists on a fee-for-service basis.</li> <li>› The Commonwealth provides Medicare rebates of 75-100 per cent of the cost of care.</li> <li>› Patients make a co-payment if there is a gap between the Medicare rebate and the doctor's fee.</li> </ul>
Dental services	<ul style="list-style-type: none"> <li>› Individuals bear most costs on a fee-for-service basis.</li> <li>› Health insurance funds and the Commonwealth PHI rebate partly subsidise the costs of people with private health insurance.</li> </ul>
Allied health and other practitioners	<ul style="list-style-type: none"> <li>› Individuals bear most costs on a fee-for-service basis.</li> <li>› Health insurance funds and the Commonwealth PHI rebate partly subsidise the costs of people with private health insurance.</li> </ul>
Medications	<ul style="list-style-type: none"> <li>› Commonwealth subsidises most of the cost of pharmaceuticals listed under the PBS and RPBS.<sup>b</sup></li> <li>› Individuals pay most of the cost of medicines not listed on the PBS or RPBS, with some costs reimbursed by health insurance funds.</li> <li>› Medications used by inpatients in public hospitals do not attract PBS benefits, and are funded by States and Territories and the Commonwealth under the AHCA. Medicines used by inpatients in private hospitals attract PBS benefits.</li> </ul>
Community health	<ul style="list-style-type: none"> <li>› Community health services – including maternal and child health, alcohol and drug rehabilitation and mental health programs – are primarily funded by State and Territory governments.</li> </ul>
Public health	<ul style="list-style-type: none"> <li>› Both the Commonwealth and the States and Territories fund initiatives aimed at protecting or promoting the health of the population.</li> </ul>

NOTE: <sup>a</sup> AHCA = AUSTRALIAN HEALTH CARE AGREEMENTS. <sup>b</sup> PBS = PHARMACEUTICAL BENEFITS SCHEME. RPBS = REPATRIATION PHARMACEUTICAL BENEFITS SCHEME.

In 2005-06, funding for the Australian health care system came from four major sources: the Commonwealth Government (43 per cent); State and Territory and local governments (25 per cent); individuals (17 per cent); and private health insurance funds (7 per cent). The funding arrangements for each main type of health services are summarised in Table 3.

TABLE 3: SOURCE OF FUNDING FOR MAIN HEALTH SERVICES, 2005-06

Service type	Source of funding						Total expenditure (\$b)
	Commonwealth		States & Local Govt	Health insurance funds	Individuals	Other	
	Direct outlays	PHI rebate					
Public hospitals	41%	1%	51%	2%	2%	4%	\$24.3
Private hospitals	14%	23%	4%	46%	4%	9%	\$6.7
Patient transport	8%	3%	62%	6%	15%	5%	\$1.4
Medical services	77%	2%	0%	4%	11%	6%	\$15.5
Dental services	2%	7%	10%	14%	67%	0%	\$5.3
Allied health and other practitioners	17%	6%	0%	13%	54%	9%	\$3.0
Benefit-paid pharmaceuticals	83%	0%	0%	0%	17%	0%	\$7.3
Other medications	1%	1%	0%	1%	96%	1%	\$4.2
Aids and appliances	10%	5%	0%	9%	74%	2%	\$2.8
Community health	11%	0%	81%	0%	4%	4%	\$3.9
Public health	54%	0%	43%	0%	3%	0%	\$1.5
<b>Total<sup>a</sup></b>	<b>39%</b>	<b>4%</b>	<b>25%</b>	<b>7%</b>	<b>17%</b>	<b>8%</b>	<b>\$86.9</b>

NOTE: <sup>a</sup> TOTAL INCLUDES ADMINISTRATION AND RESEARCH. SOURCE: AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE (AIHW) 2007, HEALTH EXPENDITURE AUSTRALIA 2005-06, HEALTH AND WELFARE EXPENDITURE SERIES NO. 30, CAT. NO. HSE 50, CANBERRA, TABLE A6.

## 2.3 Growing Health Pressures

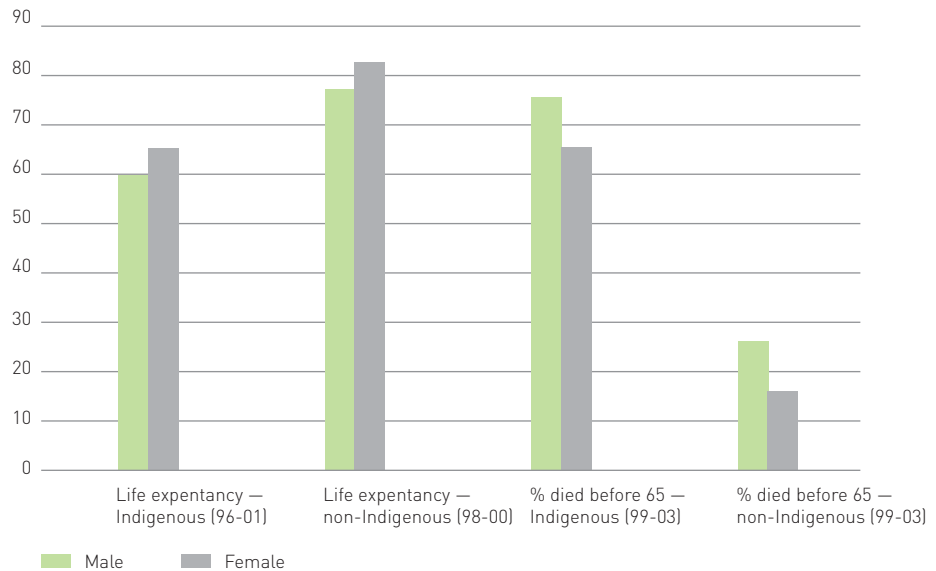
Australians are generally healthy and have access to high quality health care. Our health outcomes are among the best in the world, and we achieve these outcomes at a reasonable cost, just below the OECD median.<sup>2</sup> Yet good health is not equally shared by all people in Australia, and health inequalities are particularly marked among the most disadvantaged, especially Indigenous communities.

The sustainability of health care currently available to Australians is being threatened by pressures on a number of fronts. Several large-scale shifts – an ageing population, the changing burden of disease, the rising cost of and demand for new medical technologies, and significant health workforce constraints – are combining to generate strong growth in both utilisation and costs.

### Health inequalities

Despite marked improvements in the overall health of Australians over the last century, health gains have not been shared across all sections of the population. A number of groups in Australia do not enjoy the same level of health as the general population, most notably Indigenous people, those living in rural and remote areas, and socio-economically disadvantaged communities. These populations have higher rates of death, experience poorer health, and are more likely to have risk factors that contribute to disease. Such inequalities can be dramatic. For example, there is a life expectancy gap of 17 years between Indigenous peoples and other Australians (see Figure 3). Indigenous Australians also suffer disproportionately from chronic diseases, and experience higher levels of disability.<sup>3</sup>

FIGURE 3: LIFE EXPECTANCY AND EARLY DEATHS BY INDIGENOUS STATUS



NOTE: EARLY DEATHS FIGURES ARE FOR QUEENSLAND, SOUTH AUSTRALIAN, WESTERN AUSTRALIAN AND THE NORTHERN TERRITORY ONLY.  
 SOURCE: AUSTRALIAN BUREAU OF STATISTICS (ABS) AND AIHW 2005, THE HEALTH AND WELFARE OF AUSTRALIA'S ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES, CAT. NO. 4704.0, CANBERRA.

2 MEASURED BY HEALTH EXPENDITURE AS A RATIO OF GDP. AIHW 2007, HEALTH EXPENDITURE AUSTRALIA 2005-06, HEALTH AND WELFARE EXPENDITURE SERIES NO. 30, CAT NO. HSE 50, CANBERRA.

3 AIHW (AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE) 2006, CHRONIC DISEASES AND ASSOCIATED RISK FACTORS IN AUSTRALIA 2006, CAT. NO. PHE 81, CANBERRA, P.56.

4 PRODUCTIVITY COMMISSION 2005, ECONOMIC IMPLICATIONS OF AN AGEING AUSTRALIA, RESEARCH REPORT, CANBERRA; OECD 2007, HEALTH AT A GLANCE - OECD INDICATORS 2007, PARIS; COMMONWEALTH OF AUSTRALIA 2006, THE BLAME GAME: REPORT ON THE INQUIRY INTO HEALTH FUNDING, HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING, CANBERRA.

5 AIHW 2007, HEALTH EXPENDITURE AUSTRALIA 2005-06, HEALTH AND WELFARE EXPENDITURE SERIES NO. 30, CAT NO. HSE 50, CANBERRA.

6 COMMONWEALTH OF AUSTRALIA 2007, INTERGENERATIONAL REPORT 2007, CANBERRA, PART 2.

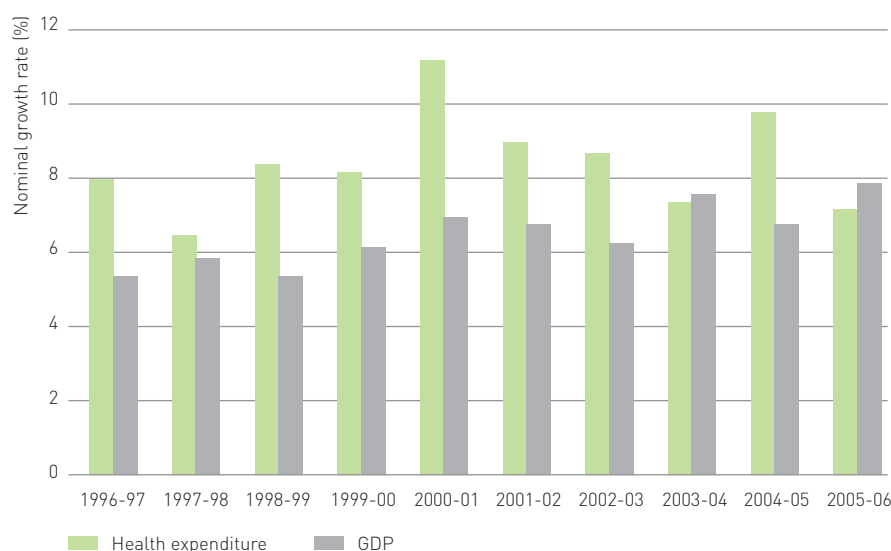
7 PRODUCTIVITY COMMISSION 2005, ECONOMIC IMPLICATIONS OF AN AGEING AUSTRALIA, RESEARCH REPORT, CANBERRA.

### Unsustainable growth in health costs

The Productivity Commission, the OECD and other bodies have confirmed that managing health costs is the single biggest fiscal pressure facing governments.<sup>4</sup> In the decade to 2005-06, health expenditures outpaced economic growth by an average of 2 per cent each year (see Figure 4). Australians now spend more than \$4200 per person on health care, which represents 9 per cent of GDP.<sup>5</sup>

In Australia, however, the most rapid growth in health expenditure has been by individuals. Over the ten years to 2005, the proportion of total health spending paid by individuals in out-of-pocket costs rose from 15.9 per cent (\$335 per person) to 18.2 per cent (\$750 per person). This is higher than the OECD average of 15.5 per cent. However Australians' out-of-pocket spending on health care as a proportion of household final consumption expenditure is equal to the OECD average (2.8 per cent), suggesting that the level of individual contributions is in line with international standards.

FIGURE 4: GROWTH IN HEALTH EXPENDITURE AND GDP, 1996-97 TO 2005-06



SOURCE: AIHW 2007, HEALTH EXPENDITURE AUSTRALIA 2005-06, HEALTH AND WELFARE EXPENDITURE SERIES NO. 30, CAT. NO. HSE 50, CANBERRA.

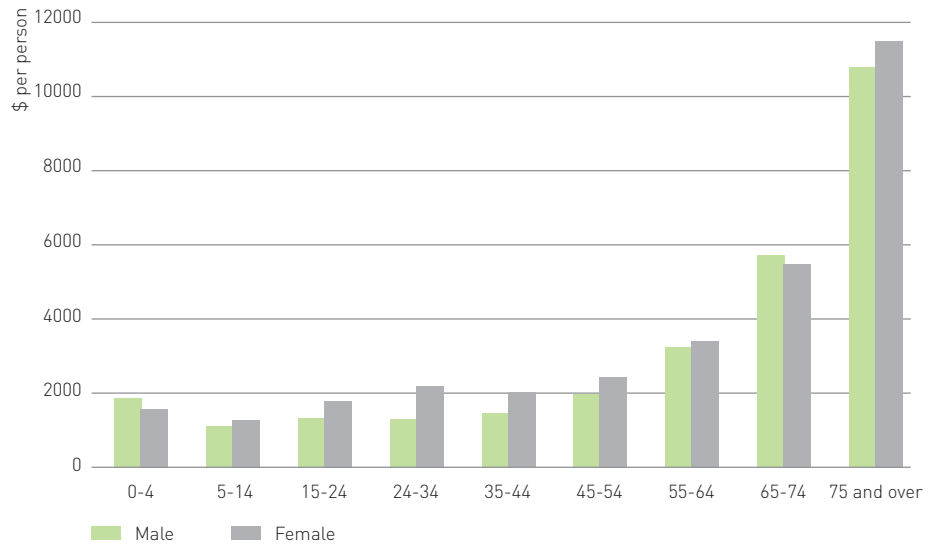
### An ageing population

Australia's population is ageing and this will have a dramatic effect on demands for health care. By 2047, over one in four Australians will be over 65.<sup>6</sup> Figure 5 shows that people over the age of 65 years are likely to use considerably more health services than younger Australians. While population ageing is not the main driver of rising costs, the Productivity Commission estimates that government expenditure alone on health will rise to around 10.3 per cent of Gross Domestic Product by 2044-45 – with population ageing responsible for one-quarter of this expenditure.<sup>7</sup>

The ageing of the population will heighten the importance of keeping people well and helping them to age healthily so they can maintain their independence for as long as possible.

- 8 AIHW 2006, CHRONIC DISEASES AND ASSOCIATED RISK FACTORS IN AUSTRALIA 2006, CAT. NO. PHE 81, CANBERRA, P. IX.
- 9 BEGG S, VOS T, BARKER B, STEVENSON C, STANLEY L, LOPEZ AD. 2007, THE BURDEN OF DISEASE AND INJURY IN AUSTRALIA 2003. PHE 82. CANBERRA: AIHW.
- 10 IBID, P. 73.
- 11 NATIONAL HEALTH PRIORITY ACTION COUNCIL 2006, NATIONAL CHRONIC DISEASE STRATEGY, AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND AGEING, CANBERRA, P. 13.
- 12 AIHW 2007, AUSTRALIAN HOSPITAL STATISTICS 2005-06, HEALTH SERVICES SERIES NO. 30, CAT. NO. HSE 50, CANBERRA, PP XVIII.
- 13 AIHW 2005, HEALTH EXPENDITURE OF DISEASES AND INJURIES IN AUSTRALIA 2000-01, 2ND EDITION, CANBERRA.
- 14 PRODUCTIVITY COMMISSION 2005, IMPACTS OF ADVANCES IN MEDICAL TECHNOLOGY IN AUSTRALIA, RESEARCH REPORT, MELBOURNE, P. XXVIII.
- 15 PRODUCTIVITY COMMISSION 2005, IMPACTS OF ADVANCES IN MEDICAL TECHNOLOGY IN AUSTRALIA, RESEARCH REPORT, MELBOURNE.

FIGURE 5: AVERAGE HEALTH EXPENDITURE (PUBLIC AND PRIVATE) BY AGE GROUP, 2000-01



SOURCE: AIHW 2004, HEALTH SYSTEM EXPENDITURE ON DISEASE AND INJURY 2000-01, SECOND EDITION, CANBERRA, TABLE 8, P. 22.

**Increasing burden of preventable disease**

The relatively good health outcomes of Australians mask a growing burden of preventable chronic disease, and an increasing prevalence of risk factors associated with disease. In 2004-05, 77 per cent of Australians were judged to have at least one long-term chronic health condition.<sup>8</sup> Diabetes prevalence has more than doubled over the past two decades, and now affects around one million Australians. By 2031, it is expected that 3.3 million Australians will be affected by the disease.<sup>9</sup>

Chronic and preventable illnesses harm and limit the lives of many people, reducing their quality of life and their opportunities. Yet about one third of the chronic disease burden is attributable to common risk factors, such as smoking, excess weight, physical inactivity and poor diet (See Table 4)<sup>10</sup>. Nine in ten adult Australians have at least one of these common risk factors, with 54 per cent of males and 45 per cent of females having a combination of two or more. Aboriginal and Torres Strait Islander peoples are at heightened risk of having all of these common risk factors.<sup>11</sup>

In addition to the human costs, preventable health conditions result in unnecessary pressure on the health system. In 2005-06, over 678 000 hospital admissions – 9.3 per cent of total admissions to public and private hospitals – could have been prevented.<sup>12</sup> About 60 per cent of these admissions were attributed to chronic conditions such as diabetes, asthma and congestive heart failure, which in many instances are amenable to prevention. The potential savings are huge: it has been estimated that chronic diseases account for almost \$30 billion or nearly 60 per cent of allocated health expenditure.<sup>13</sup> Preventable disease is placing unnecessary pressure on health expenditure and health systems, while reducing the capacity of individuals to contribute to and enjoy the benefits of a growing and productive economy.

TABLE 4: RELATIONSHIP BETWEEN CHRONIC DISEASES AND RISK FACTORS

	Poor diet	Physical inactivity	Tobacco use	Alcohol misuse	Excess weight	High blood pressure	High cholesterol
Heart disease	X	X	X	X	X	X	X
Stroke	X	X	X	X	X	X	X
Cancer	X	X	X	X			
Depression	X			X	X		
Diabetes	X	X			X		
Asthma			X		X		

SOURCE: AIHW 2002, CHRONIC DISEASE AND ASSOCIATED RISK FACTORS IN AUSTRALIA 2001, CANBERRA, ADAPTED BY CANCER COUNCIL VICTORIA.

### Rising cost of and demand for new medical technologies

Medical technology is one of the most significant drivers of increased health expenditure.<sup>14</sup> New technologies contributed about one-third of total growth in spending on health in the 1990s. These cost increases are not necessarily problematic, however, given that new technologies have significantly increased the range of treatment options available to Australians, improving both health outcomes and people's experiences of health care.

The critical question is whether the benefits justify the cost. The Productivity Commission has noted that the estimated cost effectiveness of individual technologies varies widely.<sup>15</sup> Yet there are currently limited incentives to consider the relative costs and benefits of a treatment and its alternatives.

As a wider range of treatments and technologies becomes possible, consumer expectations are raised that these will be funded and available. This raises difficult questions about what level of health care we, as a community, are prepared to pay for, and on what basis. There is a growing need to engage the Australian community in a conversation about the services a universal health care system should cover in the future.

### Health workforce capacity constraints

Australians depend upon a properly trained and well-distributed health care workforce to deliver the health care we need. Yet the availability of well-trained health care professionals is a continual challenge in today's health care system, particularly in rural and remote areas and in Indigenous communities.

The current workforce shortages are some of the most serious problems facing Australia's health system. Despite increased investment in recent years, there are growing workforce shortages across a diverse range of services and occupations. This is due to the health workforce declining as a percentage of the total population, insufficient undergraduate and vocational and education training places, increased workforce mobility and increasingly aggressive national and international campaigns to attract trained practitioners in the face of similar shortages worldwide. Although workforce capacity has been partially addressed through recent COAG initiatives, more work is urgently needed.

16 PRODUCTIVITY COMMISSION 2005, REVIEW OF NATIONAL COMPETITION POLICY REFORMS, REPORT NO. 33, CANBERRA.

17 AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS 2002, A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE, SEPTEMBER, P. 3, QUOTED IN ALLEN CONSULTING GROUP 2004, GOVERNMENTS WORKING TOGETHER: A BETTER FUTURE FOR ALL AUSTRALIANS, MELBOURNE.

18 COUNCIL OF AUSTRALIAN GOVERNMENTS 2006, COMMUNIQUÉ, 10 FEBRUARY.

## 2.4 The Urgent Need for Action

In isolation, each of these challenges is perhaps manageable enough for the current system to be able to adapt. But in combination, these factors are rapidly placing the health care system under unprecedented pressure. Over time it will become increasingly difficult to respond. The Productivity Commission argues that while Australia's health system currently performs well against a number of international performance indicators, it is 'beset by widespread and growing problems'<sup>16</sup> that if left unattended will threaten the sustainability of Medicare and universality.

The health system is poorly equipped to adapt to its changing environment. The fragmentation of the system – in particular the complex split in responsibilities of the Commonwealth and State Governments – imposes 'artificial and arbitrary boundaries on consumers and health care professionals who need to manage episodes of care in a flexible and coordinated manner'.<sup>17</sup> Funding arrangements do not encourage continuity of care, provision of multidisciplinary care, or provision of care in the most clinically appropriate setting. There is disjunction between the public and private sectors in terms of funding and service provision and remuneration arrangements are unrelated to outputs and outcomes.

Tackling these factors requires comprehensive reform – yet most of our past reforms have tended to be incremental. Whereas other areas of the economy have undergone significant structural and microeconomic reform over the last two decades, the health sector has remained largely untouched. There is considerable scope to improve the productivity and efficiency of the health system, as well as to deliver better health outcomes. With health expenditure accounting for an increasingly large share of the nation's GDP, and the importance of good population health to economic productivity, failing to act decisively now risks a large future strain on the economy.

The challenges we now face require reform of matching magnitude and urgency.

## 2.5 A Strong Foundation for National Health Reform

There is widespread support across the health sector, academia and the community for systematic, national health reform. The Commonwealth Parliament itself has undertaken three major inquiries into health funding and Medicare. Many important and sensible recommendations from these inquiries are yet to be seriously examined by governments.

Questions about the sustainability of the health system and the need for reform have been raised by the Council of Australian Governments. In 2006, through its National Reform Agenda (NRA), COAG recognised the fundamental link between good health and increasing national workforce productivity and participation. In response, COAG committed to undertake actions to:

- › reduce the incidence of chronic disease and the prevalence of key risk factors that contribute to chronic disease, through health promotion, prevention and early intervention strategies and investment; and
- › increase the effectiveness of the health system, as a necessary step to significantly enhance overall national productivity. COAG agreed that financial incentives were needed to support the best possible utilisation of health resources for the purposes of advancing health outcomes.<sup>18</sup>

In December 2007, COAG recognised the unique opportunity for Commonwealth-State cooperation and identified health and ageing as one of the key areas for its 2008 reform agenda. COAG also agreed to reform the Commonwealth-State funding arrangement by focusing more on outcomes.

The COAG Reform Agenda thus provides a framework for a national discussion on the effectiveness of Australia's health system and future directions for reform. With a key component of the COAG Reform Agenda being the achievement of better outcomes, reform progress must be independently assessed, transparently reported and financially rewarded. Future health reform will also rely on strong accountability arrangements with incentives for good performance.

Combined with the negotiation of the new national health care agreement, which will be signed in December 2008 with a commencement date of 1 July 2009, the COAG Reform Agenda provides an opportunity to deliver health reforms that make a substantial difference to the health outcomes of Australians.

At the second Council of the Australian Federation (CAF) meeting in February 2007, all States and Territories agreed to a number of principles for further health reform. These are detailed in Box 2.

#### BOX 2: COUNCIL OF AUSTRALIAN FEDERATION PRINCIPLES FOR HEALTH REFORM

**Quality and safety.** Quality, safety and evidence-based practice are fundamental drivers of health care.

**Increase patient-centred care.** The health system and its financing should support more patient-centred care, including improved health consumer experiences, greater continuity of care and improved health outcomes, while continuing to promote universality, equity of access, and patient choice.

**Strengthen primary care.** Strong primary health care, including primary medical care and community-based health services, underpins health system improvement.

**Reduce the health gap.** The gap between those with the best health and those with the worst health, in the Australian population, should be reduced. This should occur through particular effort to improve the health status of population groups with the greatest need, in particular Aboriginal and Torres Strait Islander peoples.

**Increase robustness and flexibility.** The health system must be robust enough to ensure sustainability to external pressures, and flexible enough to adapt to new circumstances. The system must have the capacity to progress innovation and develop value-added service models that deliver improved patient care and better health outcomes.

**Improve responsibility-sharing for funding, risks and benefits.** Responsibility for health services is shared across levels of government, but more clarity is needed on the responsibilities at each level. Governments should work together to make a realistic assessment of the cost of delivering health services. This needs to be matched by more appropriate contributions from governments and other funders (e.g. private health insurance) so that health service funding requirements are met. The financial risks and benefits should be shared between levels of government.

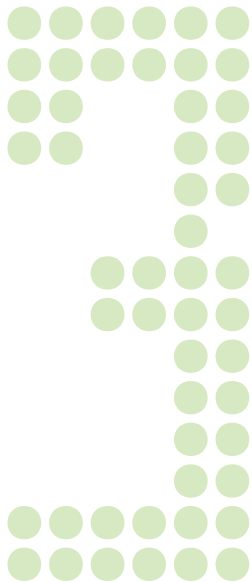
**Improve the use of health information.** Health information will empower individuals, providers and communities.

**Improve the health system.** Health system improvement needs to be viewed in its entirety, across all parts of the health care system. The societal determinants of health must be taken into account in planning and implementing system improvements.

**Strengthen the health workforce.** Workforce development is vital to reform, including continuous improvement in the level, mix and distribution of health care professionals.

The progress that has been made at COAG and CAF demonstrates that our federal system offers the best prospects for moving forward with national health reform in an efficient, productive and responsible way. Australians value checks and balances within their political system. They prefer power to be dispersed among Commonwealth and State Governments. Federalism enables different policies to co-exist, allowing the community to observe different policies and compare their effectiveness in a way that is not possible under a unitary system. A federal approach is also better placed than a centralist system to reflect and meet local needs. In a country of such vast geography, responsibility should be devolved to the lowest level at which it can be discharged effectively.

Through government leadership bodies such as COAG and CAF, the urgency of the challenge facing us has been acknowledged, and important principles for reform have been agreed. We need to build on these foundations to implement a series of reform proposals, in both the immediate and medium-term, that will begin to transform our nation's health system for the future.



# KEEPING AUSTRALIANS FIT AND HEALTHY

PAGE > 19

19 NATIONAL PUBLIC HEALTH PARTNERSHIP 2006, THE LANGUAGE OF PREVENTION, MELBOURNE.

20 AIHW 2006, NATIONAL PUBLIC HEALTH EXPENDITURE REPORT 2004-05, HEALTH AND WELFARE EXPENDITURE SERIES NO. 29, CAT NO. HWE 36, CANBERRA.

## 3.1 Introduction

This chapter addresses the first goal – that Australians are fit and healthy.

While Australians enjoy health outcomes that are among the best in the world, not everyone has shared in the health gains of recent decades. A growing number of people suffer from chronic disease, and in many cases the onset of disease could have been prevented. Preventable disease and the risk behaviours that contribute to it are especially pronounced in areas of socioeconomic disadvantage.

Keeping people fit and healthy, emphasising good health from birth, throughout life, and as we age, has to become a national priority, and an explicit goal. This is largely about prevention – avoiding risk factors, preventing the onset of disease, and intervening early if disease does occur. Above all, our goal is concerned with primary prevention – taking action to avoid or remove the causes of health problems before they occur, to control exposure to risk, and to promote factors that are protective of health.<sup>19</sup>

The framework we have adopted to address this goal – the desired outcomes, key challenges, reform directions and specific reform proposals – is presented in Figure 6.

FIGURE 6: FRAMEWORK FOR REFORMS TO KEEP AUSTRALIANS FIT AND HEALTHY



Progress towards achieving this outcome needs to be measured. An indicative list of necessary indicators is given in Table 5, but further indicators will need to be developed and employed to adequately measure progress.

TABLE 5: INDICATORS TO MEASURE PROGRESS AGAINST THE OUTCOME

Outcome	Indicators
A reduction in the prevalence of key risk factors that contribute to chronic disease, including mental health	<ul style="list-style-type: none"> <li>› Proportion of people consuming at least the recommended daily fruit and vegetable intake</li> <li>› Proportion of people overweight or obese</li> <li>› Proportion of people insufficiently physically active to obtain a health benefit</li> <li>› Proportion of people in risk and high risk alcohol consumption categories</li> <li>› Proportion of adults who are daily smokers</li> <li>› Proportion of people with substance abuse (drugs)</li> <li>› Proportion of people with high or very high reported levels of psychological distress</li> </ul>

## 3.2 Key Challenges

### There is not enough focus on or investment in effective initiatives aimed at supporting people to keep fit and healthy

Our health system focuses predominantly on coping with illness, not promoting health and wellbeing. Spending on keeping Australians fit and healthy has not kept pace with the dramatic increase in preventable diseases such as type 2 diabetes.<sup>20</sup> In 2004-05, governments spent only 1.7 per cent of their total recurrent health expenditure on public health activities. This figure has not increased since reporting began in 1999.

When it comes to health, short-term and urgent needs take priority over long-term investments and commitments. This happens for a range of financial, political and historical reasons, but it also happens because promoting health and wellbeing is not a simple task. A sustained focus on health must reach beyond the traditional health care sphere. It requires a 'healthy public policy' orientation across government and society, in areas as diverse as taxation, transport and natural and built environments.

Yet public health efforts are proven to be incredibly cost-effective. When the overall value of investments in prevention is measured – through such benefits as improved workforce participation, productivity and economic growth – the benefits to society are huge, as indicated in Table 6.

It has been acknowledged by all governments that a greater effort in promoting good health is required. Past successes – in immunisation, road safety and tobacco – demonstrate that if we made serious investments in Australians' health and wellbeing, the gains to the community would be enormous.

TABLE 6: RETURN ON INVESTMENT FOR MAJOR AUSTRALIAN PUBLIC HEALTH PROGRAMS

Program	Health outcomes	Value to society
Reduced tobacco consumption	About 17 400 fewer premature deaths in 1998	\$8.4 billion over 30 years
Reduced coronary heart disease	28 000 fewer deaths over 30 years	\$8.5 billion over 30 years
HIV/AIDS prevention	Not calculated	\$2.5 billion over 26 years
Measles immunisation	About 95 lives saved and 4 million fewer cases from 1970 to 2003	\$9.1 billion over 33 years
Road safety	About 1000 fewer deaths and 5000 fewer hospital cases per year in late 1990s	\$13.4 billion over 40 years

SOURCE: APPLIED ECONOMICS 2003, RETURNS ON INVESTMENT IN PUBLIC HEALTH: AN EPIDEMIOLOGICAL AND ECONOMIC ANALYSIS, PREPARED FOR THE DEPARTMENT OF HEALTH AND AGEING, CANBERRA.

**Investment is not always well targeted toward meeting population needs and is not sufficiently coordinated across governments and other sectors**

It is not clear that existing investments are directed to address the areas of greatest population need. Locally delivered programs to keep Australians fit and healthy often receive funding on a project-based, non-recurrent basis, resulting in little flexibility to evaluate and sustain successful interventions. The prevalence of many smaller, ad hoc initiatives means that efforts are dispersed, less able to be sustained, and compete for smaller pools of funds. There is no national mechanism to target funds to the greatest areas of need, or a process of review to sustain successful interventions.

The multidimensional nature of health promotion heightens the challenge of ensuring that investments are well targeted and coordinated. Supporting people to stay fit and healthy is not simply a health department responsibility, because health is influenced by many personal, societal and environmental factors. For example, an environment that makes it easy to walk to the shops, or safe and pleasant to cycle to work, can increase physical activity and support health and wellbeing.

Activities to keep Australians fit and healthy are spread across government and other sectors. But roles and responsibilities for funding and guiding preventative health efforts, particularly between the Commonwealth and the States and Territories, are not well defined. This means there is a lot of activity in some areas (with many groups involved in similar health prevention initiatives) and too little in others (with some areas lacking attention and energy). This lack of coordination can lead to program overlap, fragmentation, duplication, and unacknowledged gaps.

21 GOLDSMITH LJ, HUTCHISON B AND J HURLEY 2006, 'ECONOMIC EVALUATION ACROSS THE FOUR FACES OF PREVENTION: A CANADIAN PERSPECTIVE', CHEPA WORKING PAPER SERIES, PAPER 06-01, CENTRE FOR HEALTH ECONOMICS AND POLICY ANALYSIS, MCMASTER UNIVERSITY.

22 SEGAL, L. 2006, DEVELOPING A STRATEGY FOR PREVENTATIVE HEALTH: A FRAMEWORK. CENTRE FOR HEALTH ECONOMICS, MONASH UNIVERSITY.

### The relationship between evidence and investment is not always strong

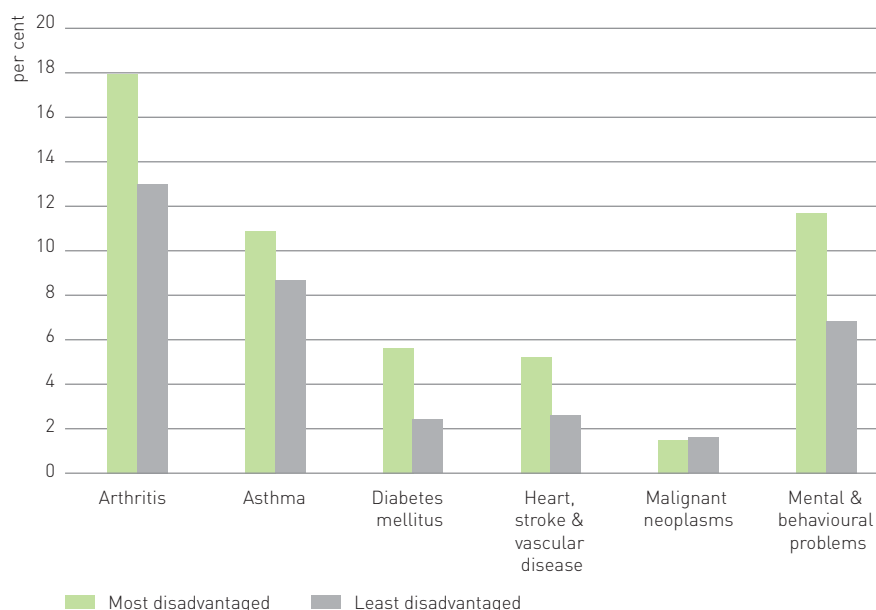
Existing efforts to keep Australians fit and healthy may not always be based on the best evidence of what works. The evidence base for prevention is underdeveloped and there is an obvious need for ongoing research. Most research has been directed at finding the evidence supporting curative medicine – or what to do once people become ill. A comprehensive review of international prevention literature found that only a small amount focused on evaluation of health promotion programs (12 per cent) or healthy public policy interventions (2 per cent) – or how to keep people healthy.<sup>21</sup> Even where research has been undertaken, there is often a failure to connect it with policy and practice. A study of over 250 Australian disease prevention programs found that there was no relationship between how cost-effective a program was, and how likely it was to receive funding.<sup>22</sup>

At the local level, the linkages between research and policy are not strong. Many planning and delivery agencies do not have the resources to properly assess and translate the existing evidence base to inform service delivery. They may not analyse the comparative effectiveness of alternative initiatives, or conduct rigorous program evaluations that would inform future program development. More importantly, individual organisations and different levels of government have no systematic, agreed processes to centrally access and exchange research findings, best practices, and program evaluations, all of which are integral to informing evidence-based policy.

### Many key risk factors for chronic disease are correlated with disadvantage, with Indigenous Australians faring particularly badly

Many chronic diseases and their key risk factors are highly associated with disadvantage. People living in socioeconomically disadvantaged areas are more likely to be smokers, physically inactive and overweight or obese. They have greater prevalence of diabetes, mental and behavioural problems, and other chronic diseases; and higher mortality for coronary heart disease, lung cancer and diabetes. Figure 7 displays the impact of disadvantage on the prevalence of selected chronic conditions.

FIGURE 7: PERCENTAGE OF PEOPLE WITH SELECTED LONG-TERM CONDITIONS, BY MEASURE OF DISADVANTAGE



NOTE: MOST AND LEAST DISADVANTAGED REFERS TO THE 1ST AND 5TH QUINTILES, RESPECTIVELY, IN THE INDEX OF DISADVANTAGE, WHICH SUMMARISES ATTRIBUTES SUCH AS LOW INCOME, LOW EDUCATIONAL ATTAINMENT, HIGH UNEMPLOYMENT AND JOBS IN RELATIVELY UNSKILLED OCCUPATIONS. SOURCE: ADAPTED FROM ABS 2006, NATIONAL HEALTH SURVEY: SUMMARY OF RESULTS 2004-05, CANBERRA.

23 AIHW 2006, CHRONIC DISEASES AND ASSOCIATED RISK FACTORS IN AUSTRALIA 2006, CANBERRA, P. 57-58.

24 IBID, P. 60.

This effect is particularly dramatic for Indigenous Australians. Compared to other Australians, nearly half of Indigenous Australians over 18 are current daily smokers; around 60 per cent report inadequate consumption of fruit and vegetables; and over 30 per cent are rated as obese.<sup>23</sup> Indigenous Australians also have much higher death rates from chronic disease than other Australians – the death rate for diabetes, for example, is nearly 14 times greater than that of other Australians. Not only are Indigenous Australians more likely to die from these diseases, they are more likely to die at younger ages.<sup>24</sup>

### 3.3 Commonwealth Government Commitments

The Commonwealth Government has recently committed to a range of initiatives to help keep Australians fit and healthy. These are detailed in Box 3.

#### BOX 3: COMMONWEALTH GOVERNMENT COMMITMENTS TO HELP KEEP AUSTRALIANS FIT AND HEALTHY

- › A plan for **Preventive Health Care For Our Families and Our Future Economy**, including a National Preventative Health Care Strategy and a Preventative Health Care Partnership between the Commonwealth and States and Territories.
- › Making **obesity a National Health Priority Area**, including evaluating obesity programs and sharing knowledge.
- › A plan for **An Equal Start in Life for Indigenous Children**, including national coverage of child and maternal health services to Indigenous Australians.
- › A **Plan for Early Childhood**, including a **Healthy Kids Check** for every 4-year-old child and **guidelines on healthy eating and physical activity** in early childhood settings.
- › Extra funding for the **National Tobacco Strategy**.
- › Developing a **National Men's Health Policy**; and a **National Women's Health Policy**.
- › **Cancer screening** for all 50-year-olds for bowel cancer.
- › Placing **mental health firmly back on the COAG agenda**, including working with States on an integrated approach to mental health service delivery, and focusing on prevention and early intervention and evidence-based approaches.
- › Commissioning the Treasury to **report on the impact of chronic diseases** on the Australian economy.

### 3.4 Reform Directions

#### Build a coherent national approach to guide the prevention efforts of government and non-government agencies

All governments, through COAG, have recognised the vital importance of good health, disease prevention and early intervention to Australia's future. The National Reform Agenda has provided an agreed direction for all governments, and resulted in substantive programs to improve health outcomes and increase the effectiveness of the health system. In 2006, COAG committed to the Australian Better Health Initiative (ABHI), a linked initiative designed to re-focus the health system and to see the Commonwealth and States and Territories working together, and with the community, to promote good health and tackle chronic disease.

These developments demonstrate the commitment of all Australian governments to work collaboratively on key health issues. However, we still lack a national plan that:

- › clearly sets out Commonwealth and State and Territory roles and responsibilities;
- › builds partnerships across sectors to leverage the benefits of coordinated efforts; and
- › commits to significant, sustainable resourcing of preventative health programs, based on agreed health improvement targets and monitoring progress against agreed outcomes.

For example, programs being implemented under the ABHI are limited in scope and not explicitly connected to broader national strategies, nor well coordinated across jurisdictions. In addition, the ABHI funding is relatively modest, and guaranteed for only four years.

The National Reform Agenda, the ABHI and other initiatives provide a strong foundation for a national road map for prevention efforts across government and non-government sectors. This would need to recognise local flexibility in the delivery of initiatives, as well as existing State and Territory work that may have resulted in valuable partner networks and public recognition.

A first step should be to agree to a partnership approach towards the governance and funding of Australia's primary prevention effort that:

- › defines the roles of individual Australians, communities, governments and employers in promoting health and wellbeing;
- › draws together a broad range of partners, from the health system, across government, and other areas of activity that impact health, in recognition of the multitude of factors that influence health and wellbeing;
- › coordinates existing programs of work and build new partnerships across sectors to best leverage preventative efforts; and
- › places a greater focus on building world-class research in prevention, and better linking research outcomes and investments.

Efforts should focus on the most vulnerable and disadvantaged populations – in the first instance, children and Indigenous Australians – and should tackle the most pressing national health priority areas, such as diabetes, cancer and mental health.

The Commonwealth Government has committed to developing a National Preventative Health Care Strategy to bring a true preventative focus to the health system, and to provide a blueprint for tackling chronic disease. The Commonwealth Government has also particularly focused on children, Indigenous Australians, cancer and mental health in its health policies to date.

### **Invest in research that promotes evidence-based practice and ensure that research is disseminated widely**

Australia has some of the world's leading researchers in areas like diabetes, and we need to continue to expand our nation's research capacity, as well as continuing to draw on international research networks for best practice. Investing in research now will provide the best available evidence to efforts to promote health and wellbeing. Investments and policy development across government and the health and community sectors need to be directed with a thorough understanding of what works best in a given environment, and effectively disseminated among health professionals, service providers and other organisations that play a role in promoting health and wellbeing.

To have the greatest effect, any new research investments should complement the priorities that are developed to guide the prevention efforts of government and non-government agencies. Investments need to be based on the principle of comparative effectiveness, and be nationally coordinated to target the areas of greatest need, ensure cross-jurisdictional learning, and maximise the value of investment.

The Commonwealth Government has committed to evaluating the benefits of successful community initiatives to tackle obesity, to ensure the sharing of lessons from successful programs.

### Encourage public and private investment in effective initiatives that support people to stay fit and healthy, particularly targeting disadvantage

Governments will need to increase their investment in preventative health, particularly as more evidence about the best interventions becomes available. But boosting investment in prevention is not only a matter of increased government spending on public health responsibilities. The complex mix of factors that promote health and fitness requires a commitment to investing in health from many organisations: government, business and not-for-profit. To make the most of that investment, action needs to be coordinated, sustained, well informed by evidence and particularly targeted at vulnerable groups, such as Indigenous Australians.

As individuals, we can do a lot on our own, such as keeping active and eating well, but for many, extra support from health professionals, family and community is critical. Information and messages about healthy eating and keeping active often do not reach those most in need. Furthermore, Australians at most risk of chronic illness face many barriers to healthy living that are associated with disadvantage. Many organisations can play a stronger role in giving everyone a chance to be fit and healthy. People can be helped through a supportive environment, access to the right information, life skills and opportunities that make healthy choices easy. In targeting disadvantage, it needs to be recognised that not everyone has the same opportunities or capacity to improve their own health and wellbeing, and investments must be targeted to those most in need.

We need to get the people who can make the most difference to health and wellbeing on board. There is great potential in encouraging private health insurers to support prevention and health promotion. Private insurance funds have an incentive to encourage healthier members and have the ability to provide support for people to stay fit and healthy. Current mechanisms, such as allied health rebates, are limited in their scope and application. Similarly, policies that build the role of employers in workplace preventative health have significant, and as yet untapped, potential. We also need to find the right mechanisms to support disadvantaged groups, who are less likely to access workplace programs, or benefits offered through private health insurance.

### Provide greater incentives for people to manage their own health

People want to be healthy, active and independent. We all have a responsibility to look after our own health and wellbeing and a strong personal incentive to minimise our risk factors for disease. To reach our own personal health and wellbeing goals, we need to be able to take control of the things that determine our health as far as possible.

The rise of lifestyle risk factors, such as physical inactivity, and associated preventable diseases, suggest that there may be a greater role for incentives to encourage healthy behaviour. Individuals already face some financial incentives to reduce health risks such as life insurance premiums related to risky behaviours, and price disincentives through taxes for smoking. There may be additional opportunities to use both positive and negative financial incentives, possibly through subsidies or rebates, to encourage people to invest in their health and fitness and maintain good health.

Personal incentives to increase healthy behaviours would be complemented by a more supportive environment aimed at giving individuals the opportunity to lead a healthy lifestyle in all the places where they live, learn, work and play.

### 3.5 Reform Proposals

This chapter has identified four key challenges to keeping Australians fit and healthy, and pointed to four directions of reform. To make real progress against the desired outcome – a reduction in the prevalence of key risk factors that contribute to chronic disease – will require concerted effort over the long term by both the Commonwealth Government and States and Territories.

Two immediate actions are proposed to be taken by COAG to lay the foundation for a more coordinated, better targeted approach to prevention that will improve health outcomes for Australians. It is also proposed that the NH&HRC explore further the area of personal responsibility and the role that could be played by employers. These reform proposals are detailed in Box 4.

These reforms will usher in a new era for the Australian health system. For the first time, there would be a substantial, shared commitment to preventative health from individual Australians, the community, government and employers. There would be a new coordinated, national focus on keeping Australians fit and healthy, from birth, throughout life, and as we age, and greater support for all Australians to reach their own health and wellbeing goals.

#### BOX 4: REFORM PROPOSALS TO KEEP AUSTRALIANS FIT AND HEALTHY

##### Immediate reform

- 1.1 Roll out Victoria's Work Health plan across Australia, giving people access to preventative health support in their workplaces.
- 1.2 Establish sub-regional "Healthy Living Partnerships" across Australia, involving the Commonwealth, States, Local government and other key partners, to strengthen and coordinate local efforts to keep people fit and healthy, as part of a new national approach to primary prevention.

##### Immediate supporting reform

- 1.3 Establish a new national "Healthy Living Accord" to be negotiated as part of the new national health care agreement, covering governance and funding of Australia's primary prevention effort, and incorporating:
  - (a) The role that can be played by individual Australians, their governments, employers and communities;
  - (b) Existing Commonwealth and State preventative effort, including through the Australian Better Health Initiative and other agreements;
  - (c) Effort from the health system, and from other areas of government activity that impact the determinants of health, such as education, planning and physical activity;
  - (d) A greater focus on building world-class Australian research in this area, and on linking research outcomes and future investment;
  - (e) Flexibility for States and Territories to take different paths in pursuit of agreed outcomes, and incentives for performance against those outcomes; and
  - (f) An initial shared focus on children, Indigenous Australians, and the key risk factors driving increasing rates of diabetes, cancer and poor mental health, particularly in rural, remote and disadvantaged communities.

##### Medium term reform

- 1.4 Further consideration by the Preventative Health Taskforce of strategies to encourage individuals to take greater personal responsibility for maintaining good health, and of the need to encourage employers to invest in the health and wellbeing of their workforce.

Specifically, these reform proposals would deliver the following benefits:

- › **To Australians** – Individuals will have greater support to keep fit and healthy. Many people stand to enjoy a longer, healthier life as a result of more effective, better targeted prevention efforts. They will have less need for intensive health care, and thus may be able to better participate in the workforce, raising their incomes. Many socio-economically disadvantaged people have the most to gain. Nationally, higher participation and productivity will deliver a stronger economy and better standard of living for Australians and their families.
- › **To the Commonwealth Government** – A greater return on its investment in preventative health, through better targeting of programs toward priority outcomes and those most in need, as well as less duplication and more coordination of effort, including partnerships with other sectors. In the medium term, the Commonwealth Government could expect to transfer some financial responsibility to individuals and employers, reducing government outlays. Better prevention outcomes would also lead to reduced demand for Commonwealth Government-funded health care services, such as the MBS and PBS, over the long term. Higher labour force participation and productivity will raise Commonwealth revenues from income taxation and the GST, and lower expenditure on welfare payments.
- › **To States and Territories** – As with the Commonwealth Government, there would be a greater return on investment in prevention and, in the medium term, reduced government outlays through individuals and employers taking on greater responsibility, and reduced demand for State health services, including public hospitals. States would have flexibility to take different paths in pursuit of agreed outcomes, and there may be incentives for performance against agreed outcomes. Higher labour force participation and productivity will support higher business turnover, which in turn will raise State and Territory taxation revenues.

# PROVIDING THE RIGHT CARE IN THE COMMUNITY

## 4.1 Introduction

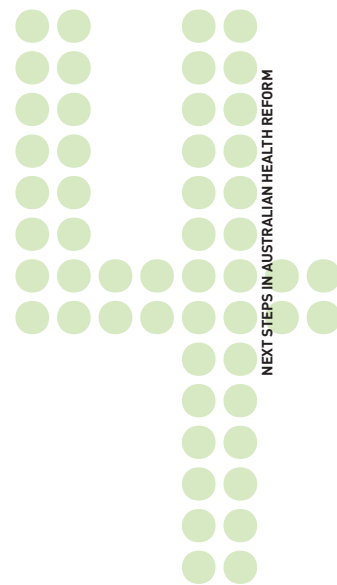
This chapter addresses our second goal – that Australians receive the right care in the community.

While many Australians can visit their family doctor or pharmacist with relatively little delay, cost or effort, for some getting the advice and treatment they need when and where they need it can be difficult. This is particularly true for the most disadvantaged Australians, notably Indigenous communities and those living in rural and remote areas. This, in turn, affects their ability to effectively manage their ongoing health needs within the realm of their home, work and place of study. The result is a higher proportion of unnecessary admissions to hospitals as well as a significant proportion of the population who are not able to participate in the workforce.

Encouraging and supporting people to access health care regularly and at an early stage of any illness is necessary for ensuring that people can better manage their own health and continue to participate in everyday activities.

Providing better primary care services is essential for patient-oriented health care that helps to keep people well, assists them to effectively manage their own illness and disability, and supports people to stay active in the workforce. There is considerable scope for improvement of primary care services, particularly in the use of e-health infrastructure to transform the patient experience. Treating people in primary care settings is more cost effective and often represents better value to the taxpayer than treating people in hospital. More importantly however, an effective primary health care system allows people to be treated close to their place of work or home, minimising disruption to their everyday lives.

The framework adopted to address this goal is presented in Figure 8.



25 COMMONWEALTH FUND 2007. INTERNATIONAL HEALTH POLICY SURVEY, CHART PACK, HTTP://WWW.COMMONWEALTHFUND.ORG/SURVEYS, ACCESSED 23 NOVEMBER 2007, P. 22.

FIGURE 8: FRAMEWORK FOR REFORMS TO PROVIDE THE RIGHT CARE IN THE COMMUNITY



Progress towards achieving this outcome needs to be measured. An indicative list of necessary indicators is given in Table 7, but refinement will be needed and further indicators will need to be developed and employed to adequately measure progress.

TABLE 7: INDICATORS TO MEASURE PROGRESS AGAINST THE OUTCOME

Outcome	Indicators
A reduction in the proportion of the working-age population not participating, or under participating, in the workforce due to illness, injury or disability	<ul style="list-style-type: none"> <li>› Proportion of the working age population not participating due to having, or caring for those with, illness, injury or disability</li> <li>› Proportion of the working age population under-participating due to having, or caring for those with, illness, injury or disability</li> <li>› Proportion of working age population on disability support benefits</li> </ul>
A reduction in the incidence of avoidable admissions and presentations to hospital	<ul style="list-style-type: none"> <li>› Proportion of potentially preventable hospitalisations for chronic disease, vaccine preventable and acute preventable conditions</li> <li>› Proportion of primary care type presentations to emergency departments</li> </ul>
An increase in the proportion of the aged population and those with illness or disability who are supported to maintain their independence in the community	<ul style="list-style-type: none"> <li>› Number of bed days for patients waiting in hospitals for suitable ongoing care</li> </ul>

## 4.2 Key Challenges

### There is a lack of coordination and continuity of care from the perspective of individuals

Patients often rely upon many people in the system – doctors, nurses, and administrators – to provide and communicate essential information, and involve others in their care, as necessary. Better coordination across the health system would increase the efficiency of the system and deliver high quality and continuous care for patients. In a recent survey of Australian patients, 18 per cent of patients reported that they had experienced problems associated with the coordination of their care.<sup>25</sup> The problems related to a prevalence of duplicate tests and health records not being available at the time of their appointment. For people who are major users of the health care system, navigating the system is itself often a complex task. The onus is often upon the patient to produce important information about themselves and their treatment, presenting high risks of sub-optimal care.

In part, the lack of coordination and continuity of patient care arises because different levels of government plan, fund and administer different stages of the care continuum. Some community services are jointly funded by two levels of government, yet primarily purchased by the States and Territories. Other services such as primary care are largely funded and purchased by one level of government (the Commonwealth) and often also involve private contributions. This split in responsibilities and funding by different levels of government means that patients can be caught between two systems. For example, frail older Australians sometimes remain in hospital longer than is clinically necessary due to a lack of appropriate alternative care, be that transition, sub-acute or aged care. In such instances the needs of the individual come second to the question of ‘who pays’.

26 H. BRITT ET AL 2007, GENERAL PRACTICE ACTIVITY IN AUSTRALIA 2005-06, GENERAL PRACTICE SERIES NO.19, AIHW CAT. NO. GEP 19, CANBERRA.

27 IBID., P. 1.

28 WORLD HEALTH ORGANISATION, ORAL HEALTH DATA, 'COUNTRY/ AREA PROFILE PROGRAMME. CRIES FOR 35-44-YEAR-OLDS BY COUNTRY/AREA', ACCESSED 21 DECEMBER 2000 AT <HTTP://WWW.WHOCOLLAB.OD.MAHI.SE/CARADCOUNTRIESALPHAB.HTML>.

29 AUSTRALIAN COUNCIL OF SOCIAL SERVICES 2006, FAIR DENTAL CARE FOR LOW INCOME EARNERS: NATIONAL REPORT ON THE STATE OF DENTAL CARE, ACROSS INFO PAPER 389.

30 AIHW 2007, AUSTRALIA'S DENTAL GENERATIONS: THE NATIONAL SURVEY OF ADULT ORAL HEALTH 2004-06, DENTAL STATISTICS AND RESEARCH SERIES, NO. 34, AIHW CAT NO. DEN 165, CANBERRA.

### There is an absence of quality and safety requirements for primary care services

The provision of safe and quality health care for Australians is central to improving health outcomes over time. Ongoing assurance of the quality and safety of care provided in primary care settings has, since the 1990s, focused on general practice. General practices can gain accreditation against the RACGP Standards for General Practices which provides tools to measure their performance with respect to health outcomes, practice efficiency and risk management. It also provides general practitioners (GPs) with access to a set of financial incentives offered by the Commonwealth Government under the Medicare Benefits Schedule (MBS), known as practice incentive payments.

Accreditation is, however, a voluntary process and occurs only every three years. While most Australians receive appropriate care from GPs, the system of accreditation lacks transparency in that it fails to spot the 'poor performers' – those practices that are not meeting the defined standards of care – and make patients aware of this risk.

Medicare billing arrangements for primary care services are not structured on a 'pay for performance' basis and hence do not provide strong incentives to improve the quality, safety or appropriateness of care. Instead, services are billed according to the length of visit and, in some cases the time of day (e.g. after hours) and setting (e.g. in the home or a residential facility). There is little information to advise for example, whether a patient has presented with key risk factors for a chronic disease, and what action has been taken to prevent the onset of disease. Similarly, the Medicare payment system does not distinguish between whether the care provided is of high or low quality.

Without the collection of dedicated information governing the type of treatment and quality of care provided to patients, the ability to improve the health outcomes of Australians at this critical interface with the health system is inhibited.

### Traditional models of primary health care are illness-driven and do not adequately meet population needs

In recent years the increase in lifestyle related health problems amongst Australians means that five out of ten GP consultations are now chronic disease-related. The challenge to meet changing population needs is significant.<sup>26</sup>

About 85 per cent of Australians visit a GP at least once a year, with GPs conducting more than 90 million consultations in 2004-05.<sup>27</sup> The historical model of primary care for patients involves a GP leading and coordinating care for the individual, acting as the first point of contact for further services within the health system. This means the GP is responsible for diagnosing, referring and coordinating care for patients with acute and serious illness.

The Commonwealth Government's approach to influencing GP practices and primary care services has been through the application of particular incentive payments (e.g. Enhanced Primary Care, Practice Incentives Program, Quality Use of Medicines, and GP Immunisation Incentives Scheme). While these incentive mechanisms are important for patient care, they are limited in their scope and MBS billing arrangements have remained predominantly time-based. This means there is limited scope or incentive for GPs and other health care professionals to provide care and treatment that focuses on prevention, early diagnosis and intervention, and disease management approaches to care.

The delivery of dental care in Australia is an acute example of existing care options not meeting patient needs. According to the World Health Organisation, the dental health of Australian adults ranks second worst in the OECD.<sup>28</sup> Around the country, 500 000 adults are on a waiting list for non-emergency dental treatment, and waiting lists are between eight months and five years.<sup>29</sup>

With most dental services delivered in private settings, the barrier for many remains the cost. In a recent survey, 91.4 per cent of those who visit a dentist paid out of pocket for the visit, and 30 per cent of Australians reported avoiding dental care due to cost. These barriers to dental care were reported more frequently by Indigenous Australians, the uninsured and people eligible for public dental care.<sup>30</sup> Public dental care in Australia is under significant pressure, with many patients waiting longer than is clinically appropriate for treatment.

#### **Access to care in the community is compromised by problems with the supply, distribution and flexibility of the primary and community health workforce**

Australians place a high value on being able to access high-quality, affordable health services under Medicare. However, there are several dimensions of the current health system that either prevent, or restrict, access to primary or community health care.

These include:

- › A lack of care or treatment options after usual business hours and on weekends; and
- › Shortages of primary health care professionals, particularly in regional and rural areas.

#### **Access after hours and on weekends**

Australians expect health care that is accessible and responsive to their needs, which includes access to an appropriately trained health care professional at night and on weekends. However, in recent years it has been increasingly difficult to provide after-hours primary medical care to patients. Less than half (47 per cent) of the GP respondents to the 2005-06 Bettering the Evaluation and Care of Health (BEACH) survey reported providing their own or cooperative after-hours patient care. This continued the downward trend reported last year (52 per cent), and compares with 56 per cent of participants in 2001-02.

This decrease in availability of GPs after hours is due to a number of factors including the growing demands on the general practice workforce, reduced participation rates in the workforce, increased proportion of female practitioners in the workforce, safety issues, and lifestyle requirements of all doctors. This has led to the declining sustainability of after-hours services.<sup>31</sup>

Australia-wide, there are a significant number of unnecessary presentations by patients to emergency departments at a time where emergency departments are coming under growing pressure from overall increases in demand. For many Australians emergency departments are seen as the most appropriate place to seek help because of a perceived need for care within hours rather than days.

### Shortages of primary health care professionals

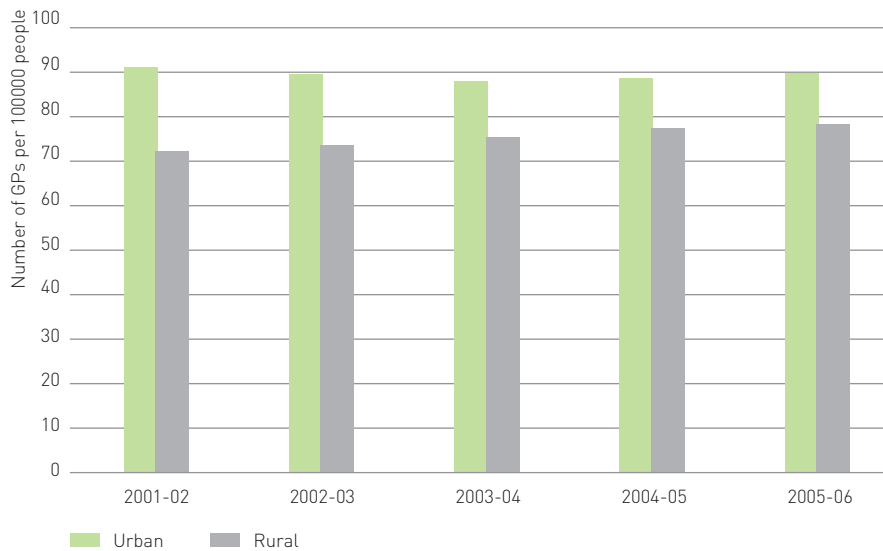
The availability (or supply) of GPs and other health care professionals affects people's access to services, particularly in rural and remote areas. Low availability can result in increased travel distance to a practice, increased waiting times to see a doctor, and difficulty in booking long consultations. Low availability may also reduce bulk-billing rates because there is less competition for patients.<sup>32</sup>

As outlined in Chapter 2, Australia is experiencing workforce shortages across a number of health professions. In addition to overall workforce shortages, there are substantial variations in the availability of GPs across regions. In terms of full-time equivalent GPs per 100 000 people, in all States and Territories except Queensland there were more GPs available in urban than rural areas in 2005-06 (Figure 9).<sup>33</sup>

The shortage of health professionals in rural and remote areas is partly attributable to the relative lack of support for health professionals to work and train outside of major capital cities. There are limited financial and non-financial rewards (including the opportunity to advance to more highly specialised and financially rewarding positions) to attract and retain enough health professionals to regional and remote areas. The shortage and uneven spread of health professionals is of particular concern given that populations in rural and remote areas suffer higher levels of mortality, disease incidence and hospitalisation.

31 H. BRITT ET AL 2007, GENERAL PRACTICE ACTIVITY IN AUSTRALIA 2005-06. GENERAL PRACTICE SERIES NO. 19. AIHW CAT. NO. GEP 19, CANBERRA.  
 32 SCRGSP (STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION) 2007, REPORT ON GOVERNMENT SERVICES 2007, PRODUCTIVITY COMMISSION, CANBERRA, CHAPTER 10.  
 33 IBID.

FIGURE 9: AVAILABILITY OF GPs (FULL TIME WORKLOAD EQUIVALENT), 2005-06<sup>a, b, c</sup>



NOTES: <sup>a</sup> URBAN AREAS CONSIST OF CAPITAL CITY AND OTHER METRO AREAS. RURAL AREAS CONSIST OF LARGE RURAL CENTRES, SMALL RURAL CENTRES, OTHER RURAL AREAS, REMOTE CENTRES, OTHER REMOTE AREAS AND OTHER AREAS. <sup>b</sup> FULL TIME WORKLOAD EQUIVALENT GP NUMBERS INCLUDE RECOGNISED GPs AND OTHER MEDICAL PROFESSIONALS WHO ARE ALLOCATED TO A JURISDICTION BASED ON THE POSTCODE OF THEIR PRACTICE. <sup>c</sup> DATA FOR NSW AND THE ACT HAVE BEEN COMBINED FOR CONFIDENTIALITY REASONS. SOURCE: SCRGSP 2007, REPORT ON GOVERNMENT SERVICES 2007, PRODUCTIVITY COMMISSION, CANBERRA, CHAPTER 10 AND ATTACHMENT 10, TABLE 10A.12.

### 4.3 Commonwealth Government commitments

The Commonwealth Government has committed to a range of initiatives to help Australians access the right care in the community. These are detailed in Box 5.

#### BOX 5: COMMONWEALTH GOVERNMENT COMMITMENTS TO HELP AUSTRALIANS ACCESS THE RIGHT CARE IN THE COMMUNITY

- › Developing a **National Primary Health Care Strategy**, including an increased focus on multi-disciplinary care from primary care teams, incentives for GPs to practice quality preventative health care, and a review of the Medicare schedule to alleviate the red tape burden on GPs.
- › A plan for **Delivering GP Super Clinics to Local Communities**, particularly in rural and regional areas.
- › Focusing on **maternal health services**, including a **commitment to combat postnatal depression** through screening and improved services; additional funding for Beyondblue and access to allied psychological services; and support for breast-feeding mothers.
- › Establishing a **Commonwealth Dental Health Program**, providing up to one million additional dental consultations, and creating a **Teen Dental Plan** to subsidise one million Australian teenagers towards the cost of an annual dental preventive check.
- › A funding boost to **improve health services in the Northern Territory**.
- › Seeking ways to **consolidate and better integrate** State-run government community health services and Commonwealth-funded GP services.

### 4.4 Reform Directions

#### Introduce greater integration and more effective management of care for patients who need it

Health care should be seamless from the patient's perspective, regardless of the number of health care professionals involved. Better links between primary and community health care providers and the acute sector are needed in order to improve the quality of care provided to patients, as well as the overall efficiency and effectiveness of the health care system.

The reform that could have the greatest impact on integration of care is the development of better e-health infrastructure. Patient health records that can be shared between health professionals and settings on a voluntary basis, with appropriate privacy safeguards for patients, have the potential to transform the health care received by Australians. Critically, e-health initiatives also put greater information in the hands of the consumer, allowing them to make better decisions about their care needs and the services they receive.

Strategies to reward GPs and other primary care practitioners who move toward new models of primary care should also be developed. New models of care would have particular regard to the utilisation of other health professionals (such as practice nurses, nurse practitioners and allied health practitioners) and new technologies. For example, a GP might work with a nurse practitioner to conduct weekly clinics on medication management for asthma patients. A more integrated service could benefit both the patient and the health system.

The development and implementation of a primary care national minimum data set would be a major step forward in the delivery of more effective management of care. This would introduce a measure of quality and type of service, as well as patient outcomes. The collection and reporting of such information would require significant up front investment and would be dependent upon effective roll-out of e-health infrastructure in all primary care settings. The introduction of reporting against a national minimum data set would ensure that where quality of care is not upheld, appropriate intervention and support could be provided to enhance patient care. In the long term, this agenda would enable the performance of primary care providers to be benchmarked against other similar practices, leading to improvements in care standards.

34 GLASGOW, NJ, SIBTHORPE, B AND A GEAR 2005, PRIMARY HEALTH CARE POSITION STATEMENT: A SCOPING OF THE EVIDENCE, AUSTRALIAN DIVISIONS OF GENERAL PRACTICE AND THE AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE, MANUKA, ACT, P. 29.

Other opportunities for enhancing primary care include encouraging primary care practices to play a greater role in identifying and acting upon areas of health concern for individuals, and greater care planning and review of patients, for example by involving other health care professionals in the development and follow-up of the care plan.

### Encourage new ways of delivering services to meet population needs more effectively and make better use of existing workforce

The delivery of care by a multidisciplinary team, including GPs, medical specialists, nurses and allied health services such as occupational therapy and podiatry will facilitate the delivery of appropriate care to patients in settings which are easy to access. The Commonwealth Government has committed to an increased focus on multidisciplinary care from primary care teams as part of the National Primary Health Care Strategy. Integrated primary care centres or 'super-clinics' would limit the need for patients to move between settings, as they will be able to access a range of health services in one place. They would also facilitate:

- › The involvement of a range of health care professionals in supporting patients with chronic disease to manage their condition;
- › A decrease in avoidable admissions and unnecessary presentations to hospitals; and
- › The establishment of professional networks to treat patients with high needs.

Super clinics established in the highest priority areas across Australia will have the opportunity to better meet the needs of the local population by using innovative service models which take account of regional needs and linking with other parts of the health system, such as outpatient departments. Infrastructure for e-health will be a key support for this. Over time, services often provided in hospitals, such as chemotherapy and dialysis treatments, may shift to such settings, allowing patients to be treated closer to home and in better circumstances.

The establishment of multidisciplinary teams for service delivery would be particularly important where primary care is inaccessible or poorly utilised, such as in regional and remote areas which receive lower than average MBS/PBS billings because of poor access to medical services. Opportunities should be explored to better fund such services, particularly where there is a shortage of GPs to meet the service demands.

### Support consumers to access care in the community

Primary care providers have a strong role in supporting people to identify health problems early, and seek appropriate treatment. Evidence is growing that self-management interventions, such as self-monitoring and decision making, lead not only to improvements in health outcomes and health status, but also to increased patient satisfaction and reductions in hospital and emergency department costs.<sup>34</sup>

For those who are less able to self-manage and self-monitor their care, better integration of services with other community and social care services will ensure care for each individual, better management of chronic disease and other illnesses and reduce the need for costly and avoidable hospital care.

One specific area that should be reformed immediately concerns the allocation of public funding for older Australians who need care in the community and aged care facilities. Many frail older Australians wait longer than is necessary in hospital for appropriate aged care. Funding for the care of frail older Australians should be an explicit Commonwealth responsibility once a person has been assessed and is waiting at home or in hospital for an aged care place. This will ensure that there are incentives for the best available care options to be pursued.

In the longer term, better arrangements for Australians attracting home and community care funding should be explored. This should include explicit consideration of the intersection between home and community care funding with aged and disability care funding, and streamlining Commonwealth/State responsibilities in these two areas. Overall, opportunities for more seamless service delivery for those receiving care should be explored.

In the area of mental health, there is a need to improve the impact and targeting of existing activity. There has been significant progress in the implementation of the National Action Plan on Mental Health. Jurisdictions have submitted progress reports, and a formal evaluation process is being established. It is evident, however, that more needs to be done to promote access to new and existing mental health services, including new MBS items, for people who need them – regardless of where they live and their capacity to pay. Ongoing, targeted investment is required to improve mental health outcomes. There also is scope to make services better coordinated, while minimising duplication and fragmentation.

There is also an imperative to enhance public dental services, particularly for those in greatest need. Addressing oral health issues at an early stage is particularly important for those with a chronic disease, as it will often prevent the emergence of more acute conditions.

The Commonwealth Government has committed to moving away from the culture of ‘6 minute medicine’ promoted by the current MBS schedule through a reform process to simplify Medicare and provide incentives for GPs to practice quality preventative health care. The Commonwealth Government has also made a significant commitment to establish a Commonwealth Dental Health Program to provide public dental services, as well as a plan to subsidise the dental costs of over one million Australian teenagers.

## 4.5 Reform Proposals

This chapter has identified four key challenges to providing the right care in the community, and pointed to three directions for reform. Five actions either underway or foreshadowed will build the foundations for change, with a further three reform areas to be considered in the medium term.

These proposals, detailed in Box 6, represent an ambitious initial agenda for reform. Concerted effort over the long term by both the Commonwealth Government and States and Territories will achieve real progress against the desired outcomes.

### BOX 6: PROPOSALS TO REFORM THE PROVISION OF CARE IN THE COMMUNITY

#### Immediate reform

- 2.1 Establish more integrated primary care 'super-clinics' in highest priority areas across Australia in ways that maximise the benefits to patient care and system performance, including by aligning with existing State funded services, using innovative service models and taking account of regional needs.
- 2.2 Enhance the level of public subsidy and public provision of dental services, particularly for those with most need.
- 2.3 Introduce a new funding mechanism for the Commonwealth to fully fund care for older Australians who have been Aged Care Assessment Team (ACAT) assessed and are waiting at home or in hospital for an aged care place.

#### Immediate supporting reform

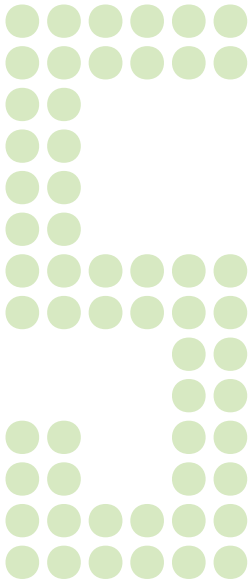
- 2.4 Establish a primary care national minimum data set.
- 2.5 Request Health Ministers to review progress in implementing the National Mental Health Action Plan, and identify opportunities to improve the impact of the additional investment contributed under that plan.

#### Medium term reform

- 2.6 Further consideration of strategies to enhance primary care services, including:
  - (a) Rewarding GPs and other primary care practitioners who shift to new models of primary care that improve patient care and health system performance;
  - (b) Encouraging primary care practices to take a greater role in improving health outcomes for people under their care;
  - (c) Development and implementation of quality and safety standards;
  - (d) Greater care planning and review of patients, including the management of chronic conditions;
  - (e) Provision of health care by the most appropriately trained professional; and
  - (f) Provision of funding for treatment of chronic disease risk factors in their own right.
- 2.7 Further consideration of mechanisms to ensure that primary care is both accessible and utilised in regional and remote areas where health workforce shortages and other constraints result in lower than average MBS/PBS billings.
- 2.8 Further consideration of the need for better arrangements in home and community care, including its intersection with aged care funding and disability care funding; opportunities for more seamless service delivery; and clarification of Commonwealth/State responsibilities.

The proposals would provide wide ranging benefits:

- › **To Australians** – Care in the community will be more accessible and more responsive to their personal needs and circumstances. It will be easier for people to find the care they need close to their home, without having to visit a hospital. Older Australians and people living in remote areas in particular will have more care options available to them. There will be more effective care planning, early intervention to address risk factors, and improved access to a range of services to foster better self-management, with stronger links between providers. All Australians stand to benefit from better health outcomes and better experiences of health care. Better health outcomes will raise some people's productivity and participation in the workforce, which will support higher incomes and a better standard of living for all Australians.
- › **To the Commonwealth Government** – There will be better value for its investment in care in the community, especially its funding of Medicare benefits. Innovations in service delivery, including through developments in e-health, will raise both the efficiency and effectiveness of primary care. Quality and safety standards and better data collection will provide the Commonwealth Government with greater assurance and evidence of the impact of its health care expenditures on Australians' health outcomes. Higher labour force participation and productivity will raise Commonwealth revenues from income taxation and the GST, and lower expenditure on welfare payments.
- › **To States and Territories** – There will be medium term savings due to lower demand for services in public hospitals, particularly outpatients and primary care type presentations to emergency departments. Clarification of roles and responsibilities for care for older Australians will reduce incentives for cost shifting. Higher labour force participation and productivity will support higher business turnover, which in turn will raise State and Territory taxation revenues.



# DELIVERING HIGH QUALITY SPECIALISED CARE

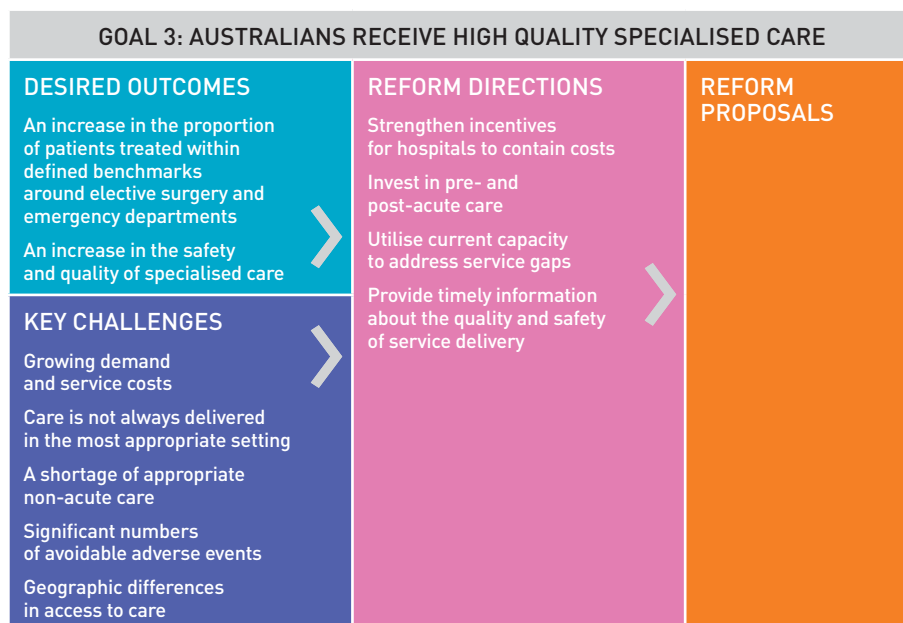
## 5.1 Introduction

This chapter addresses the third goal – that Australians have access to high quality specialised care.

The Australian hospital system provides patients with universal access and choice, through its mix of public and private hospitals. However, in order to sustain the delivery of high quality specialised care, stronger attention to stemming growth in demand and service cost is required. There is also a need for more investment in appropriate care pathways outside of the hospital setting, particularly in regional and rural areas of Australia where geographic differences in access to care result in a higher number of avoidable admissions to hospital – that is, where health problems are not identified and treated early enough.

The continued delivery of high quality specialised care that is universally available and accessible to patients who need it is a necessarily explicit goal for our health system. This is about ensuring that patients are treated in the most appropriate setting, are seen within defined benchmarks and do not have to wait longer than is clinically appropriate for care. It is also about ensuring that the care provided is safe and high quality and that important information pertaining to their care is made available to patients. The framework we have adopted to address this goal is presented in Figure 10.

FIGURE 10: FRAMEWORK FOR REFORMS TO PROVIDE THE RIGHT CARE IN THE COMMUNITY



PAGE > 40

Progress towards achieving this outcome needs to be measured. An indicative list of necessary indicators is given in Table 8, but refinement will be needed and further indicators will need to be developed and employed to adequately measure progress.

TABLE 8: INDICATORS TO MEASURE PROGRESS AGAINST THE OUTCOME

Outcome	Indicators
An increase in the proportion of patients treated within defined benchmarks around elective surgery and emergency departments	For emergency departments: › Proportion of patients treated within benchmark triage category For elective surgery: › Proportion of patients admitted within 30 days › Proportion of semi-urgent patients admitted within 90 days › Proportion of non-urgent patients admitted within a year
An increase in the safety and quality of specialised care	› Proportion of preventable adverse events; sentinel events, clinical incidents (e.g. falls, medication) › Number of hospital-acquired infections › Number of deaths associated with adverse events › Proportion of patients readmitted (unplanned) within 28 days

## 5.2 Key Challenges

### Demand and service costs are growing

On a per capita basis, Australians are using more health care than ever before and are prepared to spend more for it. It is common that as nations prosper and incomes grow, populations expect and use more and better quality health services. Demand for specialised care in Australian hospitals has increased significantly over the past decade, with hospital separations per person rising 25 per cent between 1995-96 and 2005-06.<sup>35</sup>

- 35 AIHW 2007, AUSTRALIAN HOSPITAL STATISTICS 2005-06, HEALTH SERVICES SERIES NO. 30, CAT. NO. HSE 50, CANBERRA, TABLE 2.3.
- 36 PRODUCTIVITY COMMISSION 2005, ECONOMIC IMPLICATIONS OF AN AGEING AUSTRALIA, RESEARCH REPORT, CANBERRA.
- 37 COMMONWEALTH OF AUSTRALIA 2007, INTERGENERATIONAL REPORT 2007, CANBERRA, P. 50.
- 38 AIHW 2006, CHRONIC DISEASE AND ASSOCIATED RISK FACTORS IN AUSTRALIA, 2006, CAT. NO. PHE 81, CANBERRA.
- 39 COMMONWEALTH OF AUSTRALIA 2007, THE STATE OF OUR PUBLIC HOSPITALS, JUNE 2007 REPORT, CANBERRA, P. 49.
- 40 IN VICTORIA, PRIMARY CARE TYPE PRESENTATIONS ARE INCREASING BY APPROXIMATELY 5.3 PER CENT PER ANNUM.
- 41 EHSANI, JP, JACKSON T, DUCKETT, SD, ET AL, 2006, 'THE INCIDENCE AND COST OF ADVERSE EVENTS IN VICTORIAN HOSPITALS, 2003-04', MEDICAL JOURNAL OF AUSTRALIA; 184(11) PP. 551-555.
- 42 AIHW 2007, AUSTRALIAN HOSPITAL STATISTICS 2005-06, HEALTH SERVICES SERIES NO. 30, CAT. NO. HSE 50, CANBERRA.

Alongside increased wealth and capacity to purchase more health services, Australians are increasingly aware of new medical technologies and treatments. Changing consumer expectations of good health and what is an acceptable level of chronic pain and discomfort, including a greater focus on wellbeing, have heightened demands on the system. Australians as consumers of health care are driving demand for greater choice in health products and for fast and easy access to health services. As discussed in Chapter 2, population ageing and the increasing prevalence of chronic disease among Australians have also contributed to higher demand for hospital care.

New technologies and treatments, such as a greater use of diagnostic procedures, are also likely to generate the greatest cost pressures on hospitals. Population ageing will add about one-quarter of the projected increases in spending on all health services.<sup>36</sup> Labour costs, liability and insurance issues and general price inflation also contribute to rising unit costs.

Overall, hospitals and other providers of specialised health care face the challenge of delivering an expanded range of services to meet the growing demands of the community. Keeping up with this demand will require Australian households and their governments to spend a greater share of their budgets on specialised health care. Commonwealth Government expenditure on hospitals and the private health insurance rebate as a share of GDP is expected to grow by over 80 per cent by 2046-47.<sup>37</sup>

### Care is not always delivered in the most appropriate setting

People's care needs are not always met in the setting that best matches their circumstances. In particular, too many people are treated in hospital when they could receive equally effective care closer to their home and at a lower cost.

More than one in five Australians admitted to hospital require treatment of a chronic condition.<sup>38</sup> In many cases these conditions could be treated and managed in local community settings. For example:

- › many patients recovering from a stroke or heart attack can undertake their rehabilitation in community rehabilitation centres or specialist clinics in the community;
- › technologies exist to enable minor procedures and diagnostic services to occur in primary care or dedicated ambulatory settings; and
- › palliative care and many forms of chemotherapy can be safely provided outside the acute hospital environment in community-based settings.

Provision of these services outside the hospital environment, but supported by it, can significantly improve access for patients whilst freeing up capacity in the acute sector.

In addition, many people present to hospital emergency departments with relatively minor conditions that could often be treated more quickly and appropriately by a GP, at a lower overall cost. Current Victorian data indicates that these patients constitute 45 per cent of all presentations to metropolitan emergency departments and 51 per cent of all presentations to emergency departments in larger regional hospitals. This trend is occurring nationwide, prolonging emergency department waiting times. In 2004-05, three out of every ten people presenting to emergency departments around Australia had to wait longer than the recommended time for their level of urgency.<sup>39</sup>

### **There is a shortage of appropriate non-acute care, particularly for older Australians**

Australians do not always receive care in the most effective setting, in part due to a lack of appropriate alternatives to hospital treatment, such as integrated services. The absence of other options reduces the ability of public hospitals to manage demand.

Hospitals are organised to provide bed-based service models, and typically run at very high occupancy levels. For these and many other reasons, hospitals do not meet the care needs of the growing number of frail older people or people with chronic diseases, who have multiple co-morbidities and who require extended time to recover.

Yet older Australians frequently occupy hospital beds for extended periods because they are waiting to access sub-acute, community or aged care services. The Transition Care Program was introduced in 2005-06 to provide 2000 older people with access to low-intensity therapy and care in a non-institutional environment while long-term care arrangements were being finalised. However the impact of the program has been limited, due to the number of places available, the narrowness of the eligibility criteria that excludes many people who could benefit and the difficulty for older people in regional and rural areas to access suitable residential care beds.

Shortages of GPs – especially after hours and on weekends – also increases pressure on public hospital emergency departments. Primary care type presentations to emergency departments are highest in geographic areas where fewer GPs are available. There have been some efforts to address this issue, with the Australian and State Governments supporting a number of GP clinics co-located with public hospitals in New South Wales, Victoria and Queensland. The former Commonwealth Government also provided \$5 million to improve after-hours medical care services in seven areas across Australia. However, these initiatives are relatively limited in scale and have had little effect on the overall growth of presentations.<sup>40</sup>

### **There are significant numbers of avoidable adverse events**

In a highly complex system such as health, things can go wrong. Despite the best efforts of professionals to work to minimise the risk of adverse events, they still occur.

It has been estimated that about 7 per cent of people admitted to hospital experience an adverse event.<sup>41</sup> On average, these patients remain in hospital 10 days longer than other patients and their risk of dying in hospital is seven times higher. Adverse events are estimated to cost the Australian economy \$2 billion each year. The most common causes were procedures causing abnormal reactions or complications, adverse effects of drugs and medicines, and complications of internal prosthetic devices, implants and grafts.<sup>42</sup>

The Australian Commission on Safety and Quality in Healthcare is producing many valuable resources to support health care professionals to improve the quality and safety of care. These include the national inpatient medication chart, guidelines on credentialing and scope of clinical practice, falls prevention guidelines and a patient safety education framework. However take-up of these initiatives has been variable due to the non-compulsory nature of their implementation, and there are no formal reporting mechanisms to ensure that these programs are successfully adopted. For private hospitals, there is no mechanism for 'sign-up' or endorsement, so implementation relies on good corporate citizenship.

### There are geographic differences in access to safe, specialised care

Communities in areas of regional Australia do not enjoy the same level of access to local specialised health care as people in major cities. Workforce and infrastructure issues place practical limitations on the range of services that can be provided in regional areas. It would be neither financially sustainable nor safe to provide a full range of specialised care services in each regional centre.

The number of clinical professionals with the skills and capacity to undertake procedural work is limited in some rural areas. In addition, small health services in local regional communities have limited access to the latest in medical technologies, due to cost, low throughput and a lack of specialised staff. This has led to an increasing concentration of treatment in larger centres with the facilities and skills able to provide that care.

In some areas there have been reductions in the local availability of specialised care, in order to preserve quality and safety. Some communities have been resistant to these changes, perceiving them not in terms of quality and safety but as a loss of what has been traditionally available. It is important to engage with communities to develop a shared understanding of their health care needs, the options available to them (including alternatives to specialised care), and any practical limitations to local delivery of high quality specialised care.

## 5.3 Commonwealth Government commitments

The Commonwealth Government has committed to a range of initiatives to provide high quality specialised care to those who need it. These are detailed in Box 7.

### BOX 7: COMMONWEALTH GOVERNMENT COMMITMENTS TO HELP AUSTRALIANS ACCESS SPECIALISED CARE

- › A **Health and Hospitals Reform Plan**, including funding for projects to reduce preventable hospitalisations and non-urgent emergency presentations; reduce waiting times for essential hospital services; result in fewer and shorter hospital stays for frequent hospital visitors; and increase access to medical and specialist services in the community.
- › An **Elective Surgery Plan** to reducing elective surgery waiting lists and times, including a new national public hospital report card system.
- › A plan to **Improve the Transition Between Hospital and Aged Care**, including creating additional transition care and aged care places for older Australians.
- › A **National Cancer Plan**, including funding for independent clinical trials of drugs and research into cancer treatment, and funding for new cancer centres.
- › A **Rural and Regional Nurses and Specialists Plan**, adding extra nurses and specialists to Australia's hospital system, particularly in rural and regional areas, and to aged care.

## 5.4 Reform Directions

### Strengthen incentives for public and private hospitals to contain costs

In an environment of increasing health service demand and costs, there is a growing need for purchasing decisions to be made on the basis of clinical evidence and with concern for the cost to the health system and the individual. Many States and Territories create incentives for public hospitals to use resources in the most cost-effective way through capped budgets based on activity targets and casemix funding. However, Commonwealth government funding of private hospital services through the uncapped MBS and private health insurance rebate is not driving the same efficiencies. In fact, there are few incentives for doctors practising in the private hospital sector to consider less expensive treatment options or to contain costs incurred by both the individual and the health system.

According to the Productivity Commission, existing health technology assessment processes are complex and fragmented. The Medical Services Advisory Committee (MSAC), the main health technology assessment agency responsible for advising on funding under the MBS, only undertakes limited assessments or re-assessments of existing technologies.<sup>43</sup> As a consequence, the MBS contains a large number of medical procedures commonly used in clinical practice but which may never have been subjected to a cost-effectiveness assessment.<sup>44</sup>

There is a clear need for a single, rolling and systematic approach to the use of particular health technologies and clinical practices in relation to significant health problems. Such an approach will provide an independent, evidence-based assessment of the safety, efficacy and comparative effectiveness of treatments. The resulting advice would be clear, authoritative and unbiased, and would be used to communicate findings to a wide variety of audiences, including consumers.

The development of a single health technology assessment process would provide health professionals with assurance that the technologies they employ are both safe and effective. Critically, it would also provide them with an opportunity to consider in tandem both the needs of the patient and the relative costs of alternative treatments in tandem. The use of lower cost and safe health technologies ultimately provides better value for taxpayers and health care consumers and allows the health dollar to go further.

### Increase investment in pre- and post-acute care including GP clinics co-located with hospital emergency departments, transitional care, aged care and disability services

Shortages in some forms of non-acute care, such as out of hours primary care services and transition care for frail older people, are contributing to growth in demand pressures in public hospitals. A more strategic approach to the planning of non-acute services would ensure that patients are treated in more clinically appropriate settings.

The co-location of GP clinics and/or super-clinics (as discussed in Chapter 4) with hospital emergency departments would boost access to primary medical care – particularly after hours, relieving some of the current pressure placed upon hospital emergency departments. Support for this alternative care pathway would, for some patients, be more clinically appropriate and allow faster treatment. It would also ensure that patients are cared for in a lower cost environment, representing better value for the taxpayer.

45 COMMONWEALTH OF AUSTRALIA 2007, THE STATE OF OUR PUBLIC HOSPITALS, JUNE 2007 REPORT, CANBERRA, P 40.

46 ABS 2007, PRIVATE HOSPITALS STATISTICS 2005-06, CAT. NO. 4390.0, CANBERRA.

47 MARSHALL, MN, SHEKELLE, PG, DAVIES, HTO AND PC SMITH 2003, 'PUBLIC REPORTING ON QUALITY IN THE UNITED STATES AND THE UNITED KINGDOM', HEALTH AFFAIRS 22 (3), PP. 134-148.

Given the high number of older Australians who are waiting in hospital to return home or find suitable aged care accommodation, increased investment in transitional care places is required. Effort in the first instance should be directed to establishing more transition care places in areas where there are shortages, such as rural and regional Australia. Transition care is a key stepping stone for some frail older Australians who require support to recover and return home. The creation of additional capacity in this area has the potential to alleviate current pressure on public hospitals as well as the waiting lists for permanent aged care places.

The Commonwealth Government has already committed to creating an additional 2000 Commonwealth-funded transition care places, as well as supporting aged care providers to make up to 2500 additional residential aged care places available, particularly in areas of need.

### Identify and utilise current capacity to reduce waiting times, and address service gaps

Australians' rising demand for specialised care is partly reflected in significant waiting lists for elective surgery in public hospitals. Waiting times to access elective surgery are increasing: in 2005-06, 81 per cent of elective surgery admissions were within the recommended clinically desirable time, down from 90 per cent in 1998-99.<sup>45</sup>

Yet if we consider both public and private hospitals, it is clear that existing capacity is not being fully utilised. The private sector specialises in elective surgery, yet in 2005-06, bed occupancy rates in private hospitals were reported as 78 per cent.<sup>46</sup> In the public sector, occupancy rates can exceed 100 per cent.

For certain procedures, there is significant scope for private hospitals to have a role in providing elective surgery for public patients, through selective contracting where appropriate. Governments could explore a 'risk sharing' purchasing model, in which they contract directly, through a third party or through public hospitals to make use of surplus private sector capacity. There has been limited interaction between the two sectors and the benefits to both from working more closely together in a structured arrangement have largely gone unrealised. Care needs to be taken in pursuing this path, however – especially regarding workforce issues.

Initiatives to increase elective surgery throughput could lead to an increase in demand for surgery. In order for the initiatives to have the desired effect on waiting times, it would be important for them to be combined with strategies to manage demand.

The Commonwealth Government has made a significant commitment to reduce elective surgery lists through both an immediate national blitz, and a program of systemic improvements to Australia's hospital system to increase elective surgery output in the long term.

### Provide timely information regarding the quality and safety of service delivery

Releasing timely information about the quality and safety of services can play an important role in supporting practitioners and consumers to make informed choices, while also providing an incentive for hospitals to improve performance. A growing body of evidence from the United States and United Kingdom suggests that hospitals use published information to help them focus on quality issues, improve their internal data systems, focus more strongly upon clinical governance within the organisation and, ultimately, improve the quality of care.<sup>47</sup>

There is a need for agreed national quality and safety standards that apply to all hospitals in Australia. At present, there is no common quality and safety framework between private and public hospitals. Public and private hospitals have different requirements in regard to accreditation, implementation of quality initiatives endorsed by the Australian Commission on Safety and Quality in Healthcare, reporting on sentinel events, clinical governance and infection control.

One means of strengthening the implementation of best practice in quality and safety is through links with funding arrangements. For example, funding agreements for the purchase of services in public or private hospitals could require a commitment by hospitals to implement the work of the Australian Commission on Safety and Quality in Healthcare. Achieving this commitment would provide the basis for an independent body such as the Commission to regularly report on the performance of all hospitals against agreed national quality and safety standards and outcomes.

## 5.5 Reform Proposals

This chapter has identified five key challenges to the future delivery of high quality specialised services in Australia, and has pointed to four directions for reform. Four immediate actions are proposed to be taken forward by COAG to improve Australians' access to cost-effective care in the right setting, with the National Health and Hospitals Reform Commission to further consider opportunities to improve safety and access to specialised care in rural and regional Australia.

These proposals, detailed in Box 8, represent some immediate priorities for reform. Concerted effort over the long term by both the Commonwealth Government and States and Territories will achieve real progress against the desired outcomes.

### BOX 8: PROPOSALS TO REFORM THE DELIVERY OF HIGH QUALITY SPECIALISED CARE

#### Immediate reform

- 3.1 Enhance the provision of dedicated elective surgery capacity to increase access and reduce delays, including through selective contracting of the private sector.

#### Immediate supporting reform

- 3.2 Independently assess performance of all hospitals against national quality and safety standards, minimising the reporting burden and publicly reporting outcomes.
- 3.3 Increase investment in transitional and sub-acute care where current provision is insufficient.
- 3.4 Introduce a nationally consistent, independent and transparent approach to the assessment of the comparative effectiveness of clinical care, including the use of health technologies. Recommendations to be applied across both public and private sectors.

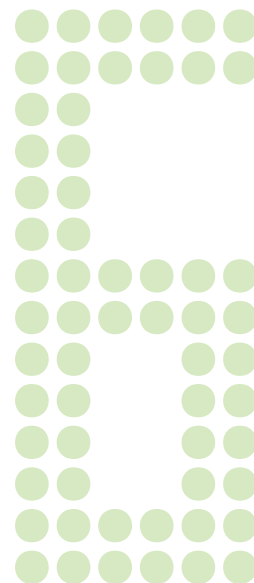
#### Medium term reform

- 3.5 Further consideration by the National Health and Hospitals Reform Commission of opportunities to improve safety and access to specialised care, particularly in rural and regional Australia.

These proposals would provide the following benefits:

- › **To Australians** – There would be better access to high quality specialised care when and where people need it. This will contribute to better health care experiences and improved health outcomes. Enhancing dedicated elective surgery capacity will reduce delays, and better availability of transitional and sub-acute care will allow more people to be treated in the most appropriate setting, including in public hospitals. Improved information will allow Australians to make better informed choices about the location of their care. In the longer term, people in rural and regional Australia will have better access to safe specialised care. Better health outcomes will raise some people's productivity and participation in the workforce, which will support higher incomes and a better standard of living for all Australians.
- › **To the Commonwealth Government** – There would be better, more consistent information about quality and safety across public and private hospitals. Greater focus on the comparative effectiveness of treatments would provide the Commonwealth Government with better value for its investment in specialised care, particularly in private hospitals. In medium term, the Government may receive some savings if older people require reduced levels of care as a result of more successful transitions. Higher labour force participation and productivity will raise Commonwealth revenues from income taxation and the GST, and lower expenditure on welfare payments.
- › **To States and Territories** – There would be benefits from more cost effective treatment, and improved provision of transitional and sub-acute care would lead to better allocation of resources to those in need of specialised care in public hospitals. Dedicated elective surgery capacity would be expected to provide some efficiency gains. Higher labour force participation and productivity will support higher business turnover, which in turn will raise State and Territory taxation revenues.

# A SUSTAINABLE AND FAIR HEALTH CARE SYSTEM FOR AUSTRALIA



## 6.1 Introduction

This chapter addresses the fourth goal – that Australians have a sustainable and fair health care system.

Australians place considerable importance on their ability to access high quality health care when and where they need it. Overall, Australia’s broad health outcomes compare favourably with those of similarly developed countries. However, for Australians to continue to have access to a world-class health system in the future, and for health outcomes to improve, major reforms are required to ensure its sustainability and fairness.

There are a number of key issues that affect the fairness and sustainability of our current health care system. These can broadly be described as the relationship between the Commonwealth Government and the States and Territories, financing and accountability arrangements, the availability of a well-trained and flexible health workforce, and the health care infrastructure that is used in delivering services. Appropriate attention needs to be paid to each of these areas, as they underpin the health system and determine its ability to deliver reform in many other areas suggested throughout this paper.

This chapter builds upon the previous chapters – looking at the health system broadly – and calls for reforms in the areas of health workforce, infrastructure, health financing and system accountability and in the roles and responsibilities of governments (Figure 11).

FIGURE 11: FRAMEWORK FOR REFORMS FOR A SUSTAINABLE AND FAIR HEALTH CARE SYSTEM

GOAL 4: AUSTRALIANS HAVE A SUSTAINABLE AND FAIR HEALTH CARE SYSTEM		
<b>DESIRED OUTCOMES</b> Australians have a sustainable health care system Australians have a fair health care system Australians have better health outcomes	<b>REFORM DIRECTIONS</b> Streamline the roles and responsibilities of the Commonwealth and States Reward allocative efficiency between preventative, primary and acute care Introduce fairer sharing of public hospital costs	<b>REFORM PROPOSALS</b>
<b>KEY CHALLENGES</b> Commonwealth and State roles are blurred Health financing creates perverse incentives States bear an unfair share of public hospital expenditure risks Accountability requirements are inconsistent Arrangements for public and private patients are inequitable Workforce shortages impact on service delivery Workforce roles have not evolved to meet needs Information systems are poorly developed Health infrastructure does not meet community needs	Ensure common requirements apply for private patients in public and private hospitals Improve accountability and information for decision making Create consistency and equity across both public and private sectors Engage with the Australian public on what they can expect from the health system Increase workforce supply and influence distribution Support flexibility and innovation in the health care workforce Increase investment in health IT to build a national e-health infrastructure Invest in physical infrastructure that supports more effective service delivery	

Progress towards achieving this outcome needs to be measured. An indicative list of necessary indicators is given in Table 9, but refinement will be needed and further indicators will need to be developed and employed to adequately measure progress.

TABLE 9: INDICATORS TO MEASURE PROGRESS AGAINST THE GOAL

Outcome	Indicators
Australians have a sustainable health care system	› Average case-mix adjusted cost per separation › Average length of stay › Proportion of health care workforce aged 55 and above
Australians have a fair health care system	› Equity of access by special needs groups
Australians have better health outcomes	› Measured through Goals 1-3

## 6.2 Key Challenges

### There is blurring, overlap and duplication in the roles of the Commonwealth and States

The recent House of Representatives inquiry into health funding estimated there is currently between \$1.1 billion and \$4 billion in waste and duplication as a result of dual roles and responsibilities between the Commonwealth and the States. The arrangements for health service delivery and funding between the States and Commonwealth are complex and fragmented. The existing AHCA has lacked transparency, with States and Territories bearing more costs than the Commonwealth over the life of the agreement. Many argue that the complex sharing of responsibilities in health results in poor accountability, service duplication and cost shifting.

The Commonwealth provides health funding through the MBS, PBS, private health insurance rebate, AHCA, and for aged care (largely to private sector providers). The States and Territories have primary responsibility for operating public hospitals through a joint funding arrangement with the Commonwealth, and they also provide ambulance services, some population health and health protection services, and community health services. There are important opportunities to refine the roles and responsibilities played by the State and Commonwealth governments in relation to health care, such as community mental health support. Effort should be paid to ensuring better integration of future health programs, with greater collaboration between the Commonwealth, State and Territory governments through both policy development and implementation phases.

### Health financing creates perverse incentives, which results in system inefficiencies

Financing arrangements for health care do not serve Australians well, either as consumers or taxpayers. A key limitation is that funding structures are not organised around the needs of patients and health outcomes. Allocations are program-specific and do not allow funds to be pooled between preventative, primary, acute and aged care. These inflexible arrangements create perverse incentives that inhibit efficient resource allocation, preventing available health budgets from having the largest possible impact on Australians' health.

For example, some people choose to attend a hospital emergency department to receive treatment they could get from a GP, because they do not want to pay a co-payment at the general practice when they face no out-of-pocket costs at the emergency department. However the overall cost of treating a person in a general practice is significantly lower than the cost of the same treatment in an emergency department. These primary care type presentations to emergency departments lengthen waiting lists and divert public hospital resources from treating those in greatest need.

Another example is the shortage of aged care beds. As discussed in Chapter 5, a large number of older Australians are waiting in public hospital beds for aged care services. The average cost per day of an acute public hospital bed is about \$967, whereas the average cost for a residential aged care bed is just over \$100 a day.<sup>48</sup> But the incentive to increase capacity in the more cost-effective form of care is weakened, because the Commonwealth is solely responsible for funding aged care, while public hospital costs are shared between the Commonwealth and the States.

### States bear an unfair share of public hospital expenditure risks

Under current public hospital funding arrangements, the State and Territory Governments bear a disproportionate share of the financial risks of increased demand and the rising costs of running the public hospital system (Figure 12). This has the potential to undermine the sustainability of providing all Australians with universal access to high quality specialised care in our public hospitals.

FIGURE 12: COMMONWEALTH AND STATE/TERRITORY GOVERNMENT FUNDING OF PUBLIC HOSPITALS, 1994-95 TO 2005-06



SOURCE: AIHW 2007, HEALTH EXPENDITURE AUSTRALIA 2005-06, HEALTH AND WELFARE EXPENDITURE SERIES NO. 30, CANBERRA.

The Commonwealth Government’s funding contribution for public hospitals is indexed at a rate considerably lower than the actual growth rate in hospital costs. Two of the three components that determine the overall indexation rate contribute to this outcome:

- › The Wage Cost Index (WCI-1) has been lower than the general level of inflation and does not reflect the actual cost of providing hospital services. Over the last decade, health inflation has been 0.4 percentage points higher than the general level of inflation.
- › The utilisation growth factor does not reflect actual growth in utilisation.

This means that in every State and Territory, the budget for public hospitals is growing at a higher rate than the indexation provided by the Commonwealth under the 2003-2008 AHCA. States and Territories have had to contribute a progressively larger share of public hospital funding as the Commonwealth’s share has steadily fallen, even though the Commonwealth’s revenue base has been healthier.

The Commonwealth’s agreement at COAG in March 2008 to provide an immediate injection of \$1 billion to relieve pressure on public hospitals in 2008-09 acknowledged that existing public hospital funding arrangements are unsustainable for States and Territories. It was also agreed that the Commonwealth should move to a proper long-term share of funding for the public hospital system in future years.

### Accountability requirements are inconsistent across providers

At present, many efforts focus on improving accountability in public hospitals but do not extend similar obligations to private hospitals, which also receive substantial amounts of public funding, or to primary and community care.

A lack of public reporting of health service performance information also provides limited incentives for health care improvements. Careful and public monitoring and benchmarking of performance, by contrast, has the potential to generate improvements in health care provision, safety, and accountability.

Current arrangements for public and private hospitals are as follows:

- › **Public reporting:** Consumers and the broader community can find out about the performance of public hospitals through a range of Commonwealth, State and Territory reports. However, accountability is limited to the published information about the performance of individual hospitals. There is no similar information available for private hospitals.
- › **Quality and safety:** There is no common framework applying to both public and private hospitals. There are different requirements on public and private hospitals and variable take-up. The differences extend to elements such as accreditation, implementation of quality initiatives endorsed by the Australian Commission on Safety and Quality in Healthcare, clinical governance and infection control.

Beyond the hospital sector there are very limited health system accountability arrangements for health care providers, with little data collected on performance and health outcomes of patients.

### Different health care arrangements for public and private patients create inequity in access and health outcomes

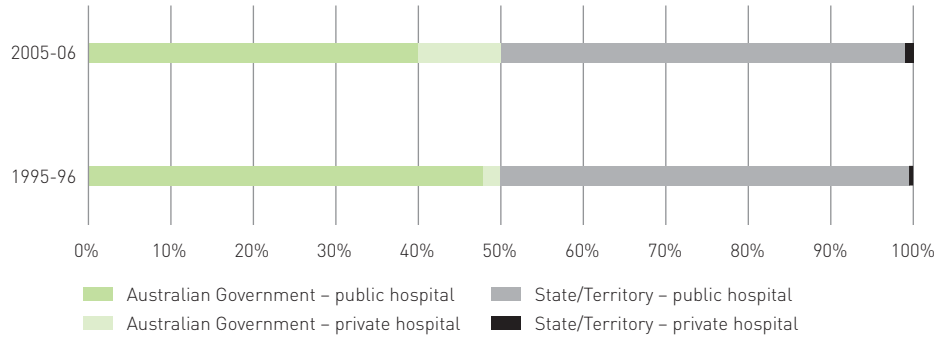
Over the past decade there have been major shifts in the composition of government funding of public and private hospitals. Most notably, the introduction of the private health insurance rebate has driven a significant increase in Commonwealth Government contributions to private hospitals.

Whereas Commonwealth Government funding of public hospitals through the AHCA is capped with a set annual rate of indexation, funding of private hospitals through the MBS, PBS and the private health insurance rebate is activity-based and largely uncapped. In the three years to 2005-06, Commonwealth Government funding of private hospitals (excluding MBS and PBS payments) grew by 8.3 per cent in real terms, compared to 3.1 per cent for public hospitals.

Overall, the Commonwealth Government's share of funding for all hospitals has declined slightly to around 50 per cent, and private hospital funding has been indexed at a higher rate than public hospitals (see Figure 13).

- 49 AUSTRALIAN MEDICAL WORKFORCE ADVISORY COMMITTEE 2005, THE GENERAL PRACTICE WORKFORCE IN AUSTRALIA: SUPPLY AND REQUIREMENTS TO 2013, AMWAC REPORT 2005.2, SYDNEY.
- 50 AUSTRALIAN HEALTH WORKFORCE ADVISORY COMMITTEE 2004, THE AUSTRALIAN NURSING WORKFORCE – AN OVERVIEW OF WORKFORCE PLANNING 2001-2004, AHWAC REPORT 2004.2, SYDNEY.
- 51 AUSTRALIAN HEALTH WORKFORCE ADVISORY COMMITTEE 2004, ANNUAL REPORT 2003-04, AHWAC REPORT 2004.3, SYDNEY.
- 52 DEPARTMENT OF EMPLOYMENT AND WORKPLACE RELATIONS, ANNUAL REPORT 2005-06, WORKFORCE PARTICIPATION, CANBERRA.
- 53 PRODUCTIVITY COMMISSION 2005, AUSTRALIA'S HEALTH WORKFORCE, RESEARCH REPORT, CANBERRA.
- 54 PRODUCTIVITY COMMISSION 2005, AUSTRALIA'S HEALTH WORKFORCE, RESEARCH REPORT, CANBERRA.

FIGURE 13: GOVERNMENT FUNDING OF PUBLIC AND PRIVATE HOSPITALS, 1995-96 AND 2005-06



SOURCE: AIHW 2007, HEALTH EXPENDITURE AUSTRALIA 2005-06, HEALTH AND WELFARE EXPENDITURE SERIES NO. 30, CANBERRA, TABLES 15, 33 AND A6; AND AIHW 1998, HEALTH EXPENDITURE BULLETIN, NUMBER 13, TABLE 17.

While it is appropriate for governments to support choice for consumers, this needs to be balanced with ensuring that high quality specialised care is available to everyone. Universal access cannot be delivered unless governments provide adequate funding for public hospitals. The challenge is to provide sustainable funding to both public and private hospitals, commensurate with their different but complementary roles. In the context of workforce shortages, maintaining some funding equity between the public and private sectors is also important to the ability of public hospitals to attract and retain health care professionals.

There are a number of other disparities in the Commonwealth Government’s support for public and private health care, which compromise both efficiency and equity objectives:

- › Privately insured inpatients can access pharmaceuticals funded under the PBS in private hospitals but not in public hospitals – causing confusion for patients and distorting behaviour.
- › Privately insured patients generally have immediate access to elective surgery in private hospitals, while people who rely on the public system face waiting lists. The absence of a rationing mechanism for private patients can result in the over-utilisation of service.
- › Across Australia, public hospitals are paid a daily rate of about \$277 for treating privately insured patients, while private hospitals are paid about \$728 for treating the same patients, despite the fact that public hospitals treat patients who are more complex and need longer hospital stays.
- › There is no requirement for people with private health insurance to utilise it in public hospitals.
- › People with private health insurance (who on average have higher incomes) receive government-subsidised dental and allied health services, whereas those reliant on the universal system typically do not.

### Shortages in the health workforce impact on service delivery, particularly in some regions

Australians depend upon the availability of a well trained health care workforce in order to receive the care that they need. However, as noted in Chapter 2, Australia is currently experiencing significant health workforce shortages. The Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC) recently found:

- › an estimated shortage of between 800 to 1300 GPs in 2002 (or around 4 to 6 per cent of the current GP workforce);<sup>49</sup>
- › a projected shortfall of between 10 000 and 13 000 nurses in 2010 – requiring at least a doubling of current graduate completions;<sup>50</sup> and
- › current and emerging shortages in the majority of medical specialities.<sup>51</sup>

Further shortages have been identified in a number of occupations, including dentists, hospital and retail pharmacists, occupational therapists, physiotherapists, speech pathologists, podiatrists, diagnostic radiographers, radiation therapists, nuclear medicine technologists, pathologists, psychiatrists, registered nurses and sonographers.

Workforce supply problems are even more pronounced in rural and remote areas and in Indigenous communities. These shortages reflect the concentration of many highly trained professionals in major cities. AMWAC and AHWAC have noted particular concerns in relation to access to GPs and certain medical specialities in rural and remote areas.<sup>53</sup> As a result of these shortages, Australians living in rural and remote areas often experience difficulties getting the care that they need.

### Roles and responsibilities of health care professionals have not evolved to meet emerging needs or service models

Without sufficient flexibility in the roles played by health professionals, the ability for Australians to receive the care they need is compromised. The need for realignment of existing health workforce roles, or the creation of new roles to make optimal use of skills and ensure best health outcomes is well recognised. But while some innovation is occurring, it often remains at the local level and can be limited in the absence of broader institutional reform.

At present, there are several barriers to improvements in work arrangements that impact upon the health care that Australians receive. These include:

- › inflexibilities and inefficiencies in workplace arrangements that can decrease job satisfaction and limit the workforce's ability to respond to changing health care needs and new technologies;
- › complex health education and training arrangements, which can lead to coordination problems and a lack of access to clinical training;
- › inconsistent approaches to, and variable quality in, accreditation processes which can impose costs on education and training institutions; and
- › a lack of reliable data on many aspects of Australia's health workforce, which can impede effective evaluation and policy formation.<sup>54</sup>

55 MENADUE, J. 2007, OBSTACLES TO HEALTH REFORM, CENTRE FOR POLICY DEVELOPMENT.

56 AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND AGEING 2005, SUBMISSION TO THE AUSTRALIAN SENATE LEGAL AND CONSTITUTIONAL REFERENCES COMMITTEE, INQUIRY INTO THE PRIVACY ACT, P. 10.

57 INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES 2001, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY, WASHINGTON, D.C.

### Health information systems are insufficiently developed and poorly integrated

Information technology, and more particularly, the introduction of e-health infrastructure, has the ability to transform the health care received by Australians. Information technology systems enable the communication of important information in a timely, reliable and secure way. Yet the information technology revolution, a driver of significant productivity gains in other parts of the Australian economy, has largely passed the health sector by.<sup>55</sup> Current health information systems in Australia do not facilitate this communication between providers, and more importantly they do not empower consumers when navigating the health care system. The use of information technology would significantly improve the quality and safety of care by better managing the exchange of information relating to patients and the care they receive.<sup>56</sup>

While many hospitals and clinics have information technology systems, they require significant integration in order to work together. There is a lack of common concepts and patterns, with each system built upon a different and incompatible foundation.

The increasing prevalence of chronic conditions highlights the need for greater integration of the current information systems. Care of these chronic conditions is often delivered by multiple clinicians – including the general practitioner, hospital and emergency department specialists, and community health providers. These health care providers can often operate as separate ‘silos’, acting without the benefit of complete information about the patient’s condition, medical history, services provided in other settings, or medications provided by other clinicians.<sup>57</sup>

### Physical health infrastructure does not meet community needs

Ageing hospitals and other health care infrastructure across all States and Territories will need to be replaced over the next 10 to 15 years. This poses significant capital costs that will need to be met from already pressured government budgets.

This also presents an opportunity to rethink the most appropriate settings for health service delivery. There is a need to assess the capital efficiency of existing health care structures and determine if they are the most efficient and effective models for the delivery of services. In some cases the cost of replacing existing health care infrastructure may outweigh the benefit to patient care. In such instances, some health care services may reasonably shift from traditional hospital settings to smaller clinics that provide more appropriate care for patients, particularly with an increasing burden of chronic conditions which may require ongoing, but not necessarily, acute care.

## 6.3 Commonwealth Government commitments

The Commonwealth Government has committed to a range of initiatives to help ensure Australians have a sustainable and fair health system. These are detailed in Box 9.

### BOX 9: COMMONWEALTH GOVERNMENT COMMITMENTS TO PROVIDE AUSTRALIANS WITH A SUSTAINABLE AND FAIR HEALTH SYSTEM

- › Establishing a **National Health and Hospitals Reform Commission**, in cooperation with the States and Territories, to develop a long-term plan health reform plan for the nation and form the framework for the development of the next Australian Health Care Agreements.
- › Increasing the **health workforce**, particularly in rural and regional areas **through extra nurses and specialists**, and additional scholarships for clinical placements for medical students and allied health students in rural areas.
- › Reforming the **Rural Medical Infrastructure Fund** to establish more medical facilities in rural areas.
- › Making both **public and private systems work together** to bring costs down and quality up.
- › A **continuing commitment** to the maintenance and improvement of Medicare, the Pharmaceutical Benefits Scheme, and the private health insurance rebate.

## 6.4 Roles and Responsibilities

### Reform Direction Clarify and streamline the roles and responsibilities of the Commonwealth and States

Clarification of Commonwealth and State and Territory Government roles and responsibilities such as funding, service delivery and reporting, would increase accountability across the health spectrum. Clarifying chains of accountability to determine more precisely who is responsible for what, and shortening the chains to make feedback on performance more direct and more timely, would allow for more responsive performance.

A solution does not necessarily lie in moving toward a centralised system where the Commonwealth takes full responsibility for health. Rather, it lies in more cooperative relationships and clearer lines of accountability with both the Commonwealth and the States and Territories working towards meeting national outcomes. The inter-connectedness of the health system where one sector impacts on the other – for example, lack of preventative health support in primary care that leads to avoidable hospital admissions – needs to be acknowledged with the right incentives to drive reform.

Two immediate opportunities exist to make improvements in this important area. First, governments should agree that the existing regional support structures for primary care practitioners, such as the Divisions of General Practice and, in Victoria, the Primary Care Partnerships, are integrated within each jurisdiction. At present, the Commonwealth and most State and Territory governments utilise different regional structures to implement primary and community care objectives. There is little rationale for this difference in approach, with many arguing that it is duplicative and counterproductive. Agreement to utilise just one regional support structure will explicitly reduce duplication in program delivery, ensure greater value for taxpayers' money, and create a more seamless support infrastructure for primary care.

Secondly, funding for community mental health support should be allocated to State and Territory governments who will be responsible for program implementation, subject to agreed performance standards. There is duplication in this particular area of mental health service delivery, which has arisen as a result of the Commonwealth investment through the National Mental Health Plan, which had little regard for State and Territory activity in this area when developed. Delegating all funding and program management responsibility to State and Territory governments would ensure that any investment into community mental health services is well integrated and coordinated.

In the medium term, the National Health and Hospitals Reform Commission should make recommendations to COAG concerning additional opportunities to remove duplication and overlap in roles and responsibilities.

It is critical, in moving to a more sustainable, streamlined and transparent health system, that there is an appropriate forum in which emerging health policy issues and challenges can be resolved. The existing mechanisms of Australian Health Ministers Council and COAG are crucial, but need to be supplemented with decision-making mechanisms which ensure that problems are resolved at an early stage.

Given that the National Health and Hospitals Reform Commission is intended as a time-limited body (eighteen months), with a relatively discrete role to fulfil, it is critical that the National Health and Hospitals Reform Commission consider how best to support an ongoing, sustainable and dynamic discussion within the health system. Ongoing dialogue must involve all levels of government, key stakeholder bodies and those impacted by any changes – principally the public. The aim is to resolve emerging policy challenges early, with only the most critical issues being referred up to COAG.

## Reform proposals

Two immediate improvements in the roles and responsibilities of the Commonwealth Government and the States and Territories are proposed, with the National Health and Hospitals Reform Commission to further consider additional opportunities to remove duplication and overlap. These proposals are presented in Box 10.

### BOX 10: PROPOSALS TO REFORM ROLES AND RESPONSIBILITIES

#### Immediate supporting reform

- 4.1 Agreement to practical improvements in roles and responsibilities in the Australian health care system:
- (a) Regional support structures for primary care practitioners to be integrated within each jurisdiction, to reduce duplication and create a seamless support infrastructure for primary care;
  - (b) Shift funding and responsibility for Commonwealth community support programs that overlap with State and Territory acute mental health responsibilities to States and Territories, subject to agreed performance standards.

#### Medium term reform

- 4.2 Further consideration by the National Health and Hospitals Reform Commission of additional opportunities to remove duplication and overlap in roles and responsibilities.

## 6.5 Financing and Accountability

### Reform Direction Create financial mechanisms to reward allocative efficiency within and between preventative, primary and acute care, including by removing existing distortions

Australians need their governments' health care resources to flow to services that provide the greatest benefit to health outcomes. Current funding arrangements are skewed towards hospitals and more expensive specialised care treatments. More investment is needed in preventative health and lower cost settings designed to support people to actively manage their health and keep them out of hospital.

The Commonwealth Government has committed to broaden the focus of the current Australian Health Care Agreements to include prevention, primary care, acute care and the transition from hospital to residential aged care, and to develop a new Preventative Health Care Partnership with the States and Territories. The funding arrangements for public hospitals under a new broader agreement are discussed in the following section. In other priority areas such as preventative health, the Commonwealth and the States and Territories must negotiate new funding arrangements under which the financial benefits of reform are distributed in a way that is commensurate with progress in each jurisdiction. Financial incentives to the States and Territories will be an important part of any such arrangements. Since much of the financial benefit from reform is likely to come from State and Territory actions, net financial flows from the Commonwealth to the States and Territories – like those provided under National Competition Policy – will be required to maintain equity.

A second step towards better allocative efficiency would be more consistent funding mechanisms across preventative, primary and acute care. For example, MBS payments could be extended to services that are similar to GP services, such as community health, public hospital outpatient services and primary care type presentations to emergency departments. This would see the Commonwealth Government fund these services on a common basis, thereby reducing distortions caused by cost shifting.

In the longer term, a system of regional fund holding could provide the basis for much more effective and efficient use of health resources. Under this model regional fund holders would receive capitation payments to purchase health services to best meet the needs of their local population. Services could be purchased from both public and private providers on the basis of value for money and improving health outcomes. As a single purchaser with ongoing responsibility for the health outcomes of their populations, regional fund holders would have an incentive to purchase health services that represent the best value for money based on the needs of their population. They would also be held accountable for their performance in terms of efficiency and delivering better health outcomes.

### **Reform Direction** **Introduce fairer sharing of public hospital costs between the Commonwealth and States**

Australians value Medicare and the principle of everyone having access to specialised health care when they need it. However public hospitals cannot continue to deliver high quality care unless governments provide adequate funding.

Under the 2003-2008 Australian Health Care Agreement, the Commonwealth Government's funding contribution for public hospitals grew considerably more slowly than actual hospital costs. States and Territories have had to contribute a progressively larger share of public hospital funding as the Commonwealth Government's share has steadily fallen.

An activity-based funding model (as part of the new national healthcare agreement) would introduce more equitable, efficient and transparent funding for public hospitals. It would also restore more balance to the sharing of risks and costs between the Commonwealth Government and the States and Territories.

A pure system of activity-based funding would not be possible initially. Therefore, a hybrid model consisting of activity and grant-based funding should be introduced with the overarching intent of funding driving service improvements and system efficiencies. This could consist of casemix funding for admitted patients; MBS and PBS payments for outpatient services and primary care type presentations to emergency departments (as discussed above); and designated block grants for the community obligations that public hospitals fulfil, including training and development and the provision of specialised care in small rural areas, as well as ancillary services that cannot be effectively funded through an activity-based approach.

Activity-based funding would provide governments with greater transparency regarding what services are being 'purchased' by their funding contribution. It also promotes yardstick competition – if prices are set to reflect the costs of efficient providers, there are incentives for both States and Territories and individual hospitals to use resources in the most cost-effective way. Arrangements should be put in place so that no State is disadvantaged during the transition to the new funding approach.

- 58 DUCKETT, S. 2004, THE AUSTRALIAN HEALTH CARE SYSTEM, OXFORD UNIVERSITY PRESS, VICTORIA, P. 44.
- 59 AIHW 2007, HEALTH EXPENDITURE AUSTRALIA 2005-06, HEALTH AND WELFARE EXPENDITURE SERIES NO. 30, CANBERRA.
- 60 COMMONWEALTH OF AUSTRALIA 2006, THE BLAME GAME: REPORT ON THE INQUIRY INTO HEALTH FUNDING, HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING, CANBERRA.
- 61 COMMONWEALTH FUND 2007, INTERNATIONAL HEALTH POLICY SURVEY, [HTTP://WWW.COMMONWEALTHFUND.ORG/SURVEYS](http://www.commonwealthfund.org/surveys), ACCESSED 23 NOVEMBER 2007.

### Reform Direction

#### Create consistency and equity across both public and private sectors

A more sustainable, activity-based funding model for public hospitals is one critical step to restoring greater parity in public and private hospital funding.

Consistency and equity could be further enhanced with the establishment of a common cost indexation factor to apply to funding of both public and private hospitals, reflecting the common cost pressures felt by each. At present, public hospital funding through the AHCA is subject to predetermined indexation factors which do not adequately reflect health costs.<sup>58</sup> AHCA funding has grown by an average of 5.7 per cent per year over 2001-02 to 2005-06. In contrast, growth in private health insurance premiums (and, in turn, Commonwealth funding of the private health insurance rebate) is determined each year by the Commonwealth Minister for Health following applications from health funds. Commonwealth Government funding of the private health insurance rebate has grown by 10.7 per cent per year over the last five years.<sup>59</sup>

A common cost indexation factor could be built into the activity-based funding model for public hospitals, and also apply to the relevant components of private health insurance.

Beyond hospital arrangements, there is substantial inequity in the Commonwealth's subsidisation of dental services for people with private health insurance, while not providing any such support for people without insurance, who often have the greatest need. Chapter 4 put forward a proposal for an increase in the level of public subsidy and public provision of dental services, particularly for those with most need.

### Reform Direction

#### Ensure common requirements apply for private patients in public and private hospitals

Public hospitals are paid a default benefit for treating privately insured patients, which represents a fraction of the amount paid to private hospitals for treating the same patients. In a number of instances, the default benefit does not cover the public hospital's costs in treating the patient. This is inequitable, and undermines the effective and efficient operation of public hospitals. Reform is required to increase the payment made by health insurance funds to reflect actual public hospital costs.

### Reform Direction

#### Improve accountability and enhance information for decision-making by consumers and health professionals across public and private sectors and between jurisdictions

In a recent inquiry into health funding, the House of Representatives Standing Committee on Health and Ageing recommended strengthening the health system's accountability arrangements, including through increased public reporting.<sup>60</sup> While the Australian Commission on Safety and Quality in Healthcare will play a leadership role in ensuring that national standards and data sets are established to support the collection of information, there is a broader question regarding how information is made public and accessible to consumers.

Specific recommendations made by the House of Representatives Committee to improve accountability and public reporting were that:

- › public and private hospitals be accredited, and publish their accreditation reports within three months of being completed;
- › all State and Territory Governments regularly publish reports on adverse events occurring in public hospitals; and
- › the Australian Government supports the development of hospital and clinician-based performance information systems to better inform patients about the competence of health care providers and strengthen accountability of health professionals and health service providers.

### Reform Direction

#### Engage with the Australian public on what they can expect from the health system, now and in the future

A recent survey found that 73 per cent of Australians think that either fundamental changes to the health system are needed or that it needs to be rebuilt completely.<sup>61</sup> The community has high expectations about what the health care system can deliver, including aspects such as access, quality, timeliness and the use of technology. High and rising expectations in all these areas generate significant pressures on the health system.

The current shortage of reliable and timely information about health care providers, and the type of care patients can expect to receive, means that community expectations of the standards of service can often be out of step with the reality. A much clearer articulation and discussion of the standards of service that the community can expect to receive – including desired population health outcomes and the quality of care that people are entitled to receive – has the potential to increase community confidence in the health system. In addition, making information available about health services offers an opportunity for governments and service providers to engage with the community about key issues, such as costs and access, thereby allowing a robust, constructive public dialogue.

Consultation with key stakeholders, including health care consumers and community members, is widely acknowledged to be an essential feature of good health services planning, and it is now commonplace for members of the community to participate in health care decision making – both for themselves and for local communities.

However, difficult decisions are made every day at every level of the health system about what services to provide, to whom, where and when – and as a consequence, who might have to wait. This routine decision-making is rarely perceived as being central to the allocation of finite resources, and is seldom discussed in these terms. Engaging the community in these debates will help inform public expectations about health care.

Ongoing opportunities must be created for effective community engagement in debates about priorities for health care spending, and about the respective roles and expectations of individuals, governments and other agencies in ‘co-producing’ health. This will be essential to maintaining and improving the health of the Australian population, and ensuring our continuing access to well-coordinated, affordable, quality health care.

## Reform proposals

A number of reforms to the financial arrangements governing the delivery of health care are proposed.

It is expected that the National Health and Hospitals Reform Commission would engage with the public on the strengths of the Australian health system and the challenges facing it. These proposals are presented in Box 11.

### BOX 11: PROPOSALS TO REFORM FINANCING AND ACCOUNTABILITY ARRANGEMENTS

#### Immediate supporting reform

- 4.3 Negotiate a new national health care agreement, covering preventative health, primary, acute and aged care, to replace the current Australian Health Care Agreements.
- 4.4 Enhance the financial arrangements governing private patients in public hospitals by increasing, over time, the default benefit to reflect real costs for public hospital treatment.
- 4.5 Agree to establish greater consistency in reporting and accountability arrangements across all parts of the health system, and increase the provision of information to consumers to support decision-making.

#### Medium term reform

- 4.6 Further consideration of significant reform to health financing, in the context of the new national health care agreement, including:
  - (a) A new activity-based funding approach to provide States and Territories with sustainable resources for public hospitals recognising the community obligations which public hospitals fulfil (e.g. training and rural provision), and providing incentives for efficient service delivery. No State or Territory would be disadvantaged over any transition period;
  - (b) Establishment of a single, sustainable approach to indexation of Commonwealth hospital funding, covering the proposed activity-based funding approach and the relevant components of PHI premium increases;
  - (c) More consistent funding arrangements across preventative health, primary, emergency departments, acute and aged care, which reduce distortions and create incentives for the efficient allocation of resources;
  - (d) Ways to strengthen the role that private health insurance plays in improving health outcomes; and
  - (e) In the longer term, regional funding models which would see each State or Territory providing for area based decision-making on service 'commissioning' and investment priorities across preventative, primary and acute care, and interim regional approaches which may support a transition to this model.
- 4.7 Further consideration by the National Health and Hospitals Reform Commission of mechanisms to support ongoing, sustainable and dynamic discussion and resolution of emerging policy challenges.

## 6.6 Health Workforce

### Reform Direction Increase workforce supply and influence distribution

The provision of safe, timely and accessible health services is underpinned by workforce supply, distribution and design, as reflected in COAG's agreed approach to the health workforce. Local opportunities throughout the education and employment continuum must be provided if this is to be achieved in regional, rural and remote areas.

To support these opportunities it is necessary to align training to service delivery and appropriately fund clinical training, invest in capital and the cost of supervision. Improving the linkages between acute and primary health providers, providing e-learning for professional development and support and fostering interdisciplinary teams will further strengthen the regional, rural and remote health workforce.

COAG has noted that the Commonwealth and the States and Territories are undertaking significant investments to address health workforce shortages. In addition, the Commonwealth Government has made commitments to provide extra nurses, particularly in rural and regional areas, as well as bolstering support for clinical training in rural areas through new and existing scholarship schemes. While a number of additional medical and nursing university places have recently been established, the long lead times required for training mean that these additional places won't have an effect for some time. There is an urgent need for more advice on the extent of workforce shortages, including in which disciplines and geographical areas, in the more immediate term. Only upon receipt of this advice can alternative service delivery arrangements be seriously considered.

While the Commonwealth currently provides universities with a clinical loading to support medical and nursing training, that loading is not always passed on to the health services where training is provided. More transparent funding arrangements are required to better meet the actual cost of providing clinical placements and ensure funding is received by those incurring costs associated with training. The clinical loading scheme should also include allied health professions for whom clinical training costs are significant.

### **Reform Direction** **Support flexibility and innovation** **in the health care workforce**

In its report to COAG on Health Workforce, the Productivity Commission recommended that a national agency should be established to evaluate and, where appropriate, facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.

COAG's agreement to the introduction of a national registration and accreditation system for health professionals is an important first step in supporting this innovation. We need now to consider what more can be done to promote greater workforce sustainability and innovation, as well as progress to supporting full professional mutual recognition of qualifications. Significant workforce innovation needs to be considered on a national, systematic and coordinated basis in order to make serious progress towards addressing current workforce shortages.

### **Reform proposals**

Two immediate reforms to address workforce shortages are proposed. It is also proposed that the National Health and Hospitals Reform Commission would further consider funding arrangements for clinical training. These proposals are presented in Box 12.

**BOX 12: PROPOSALS TO REFORM THE HEALTH WORKFORCE****Immediate reform**

- 4.8 Improve capacity to train nurses, doctors and other health professionals in regional centres.
- 4.9 Request urgent advice about how to meet the immediate health workforce shortages of the next five years.

**Medium term reform**

- 4.10 Further consideration by the National Health and Hospitals Reform Commission of transparent funding arrangements for clinical training, including an increase in clinical loading for nursing and allied health.

**6.7 Health Infrastructure****Reform Direction****Increase investment in health IT to build a national e-health infrastructure**

Australia's Health Ministers have identified information management and technology as a critical enabler of future reform of the health system. A national electronic health records system will improve the quality and safety of health care by encouraging the use of information and communication technologies to ensure both the timely sharing of relevant information between health care workers and their patients, and the security and privacy of personal health information.

Establishment of the National E-Health Transition Authority (NEHTA) in 2005 reinforced the importance of Commonwealth-State collaboration in capturing the benefits available from a national e-health system. In 2006 COAG provided NEHTA with \$130 million to develop core national e-health standards as the essential building blocks for a national electronic health records system.

Over the next three to five years the core national e-health standards must be finalised and adopted in existing systems, and the infrastructure and training to deliver a national shared electronic health record system must be implemented. Work around ensuring the adoption of national standards in systems supporting doctors, pharmacists, pathologists, radiologists and private hospitals, and rolling out the infrastructure to enable secure communication between components of Australia's health system should be a Commonwealth priority. States and Territories should be responsible for adoption of core national e-health standards in the public hospital system.

The emergence of more advanced broadband technology provides an opportunity for more health services to be delivered through telehealth arrangements. Telehealth provides for flexibility of service delivery, particularly where there is a shortage of health professionals or patients cannot travel the long distances required to see a health care professional. The introduction of MBS funding of selected services provided through telehealth arrangements would enable GPs and other health care professionals to provide more services to patients in rural and remote areas.

## Reform Direction

### Invest in physical infrastructure that supports more effective service delivery

State Governments currently spend significant amounts on health infrastructure. Further investment is required to accelerate the construction of, and transition to, health infrastructure that supports new models of care. New and improved health infrastructure will foster changes in service delivery that, in turn, help achieve desired outcomes and facilitate an early intervention and prevention approach to health care.

There is a role for the Commonwealth Government in boosting health infrastructure on a national scale. In keeping with a partnership approach to health, Commonwealth and State and Territory Governments should have joint responsibility for the provision of key physical health infrastructure.

To this end, Victoria welcomes the establishment of the Health and Hospitals Fund by the Commonwealth Government. It is important that the Commonwealth work closely with the States and Territories to ensure that the Fund is focussed on delivering the major changes and improvements to health infrastructure that will respond to future patient needs and lead to improvements in health outcomes. To achieve this, the Fund Board will need to focus on ensuring that improvements are directed towards high priority and innovative projects.

## Reform proposals

Immediate reforms to fast-track e-health infrastructure and support telehealth services are proposed (the National Health and Hospitals Reform Commission would consider the need for a national program to deliver major changes and improvements in health infrastructure). These proposals are presented in Box 13.

### BOX 13: PROPOSALS TO REFORM HEALTH INFRASTRUCTURE

#### Immediate reform

- 4.11 Commonwealth to immediately fund and fast-track the development and roll out of 21st century e-health standards and infrastructure required for shared electronic health records, in collaboration with States and Territories on implementation.

#### Immediate supporting reform

- 4.12 Introduce MBS funding of additional selected services provided through telehealth arrangements, maximising the opportunities presented by emerging broadband technology.

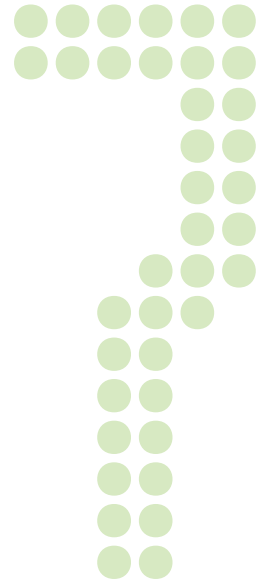
#### Medium term reform

- 4.13 The Health and Hospitals Fund to focus on improvements in health infrastructure, that respond to future patient needs.

## 6.8 Benefits of reform

Proposals to reform health care roles and responsibilities, financing and accountability arrangements, the health workforce and health infrastructure would provide the following benefits:

- › **To Australians** – There would be a more sustainable and fair health system, now and into the future. Shared electronic health records would deliver significant improvements in the quality of diagnosis and service integration across providers. Telehealth and reforms to address workforce shortages would raise Australians' access to health care. More flexible and equitable financing arrangements would allow health care resources to flow to those services that most effectively meet population needs. Improvements in health infrastructure would allow providers to adopt new models of care that respond to the communities' changing needs. Finally, Australians would have an opportunity to have their say on the health care they want for the community.
- › **To the Commonwealth Government** – The proposed financing arrangements would provide for more effective allocation of resources to areas of the greatest need, improving value for money. This would be further enhanced by the introduction of infrastructure to support shared electronic health records. Investments in workforce and physical health infrastructure would ensure that the Commonwealth Government could continue to meet its health care responsibilities. Clearer roles and responsibilities would reduce duplication and overlap, and remove distortions caused by incentives for cost shifting. Over time, telehealth may deliver some cost savings.
- › **To States and Territories** – There would be many of the same benefits received by the Commonwealth Government, including more effective allocation of resources to areas of the greatest need, and reductions in overlap, duplication and distortions caused by incentives for cost shifting. A fairer share of risks and costs between the Commonwealth Government and the States would return public hospitals to a more sustainable footing. States would also benefit from increased revenue from private patients in public hospitals.



# IMPLEMENTING AND FINANCING HEALTH REFORM

As a nation, Australia faces important choices about our health system, choices that will shape the health and wellbeing of individual Australians, and the future prosperity of our country. The time to act is now.

The agenda outlined in this paper demonstrates that national health reform is achievable – not in another five or ten years, but starting right now. This agenda could go a long way towards establishing a shared, long-term vision for Australia’s health system.

Throughout this paper, a set of overarching reform directions linked to broad long-term goals for the Australian health system has been outlined. These reform directions can be viewed as the high-level, long-term vision for national health reform – the basis of an intense program of work over the next decade.

The identified proposals for reform can act as the first instalment of a longer-term vision. We expect that many of these proposals could immediately be agreed to by Commonwealth, State and Territory governments. Other proposals will need further consideration through COAG, Health Ministers and the NH&HRC over the next 6 to 12 months.

This section outlines the immediate steps to progress reform, the mechanisms by which reform should be implemented, the objectives and principles for implementing reform, and how progress would be measured against the goals.

## 7.1 Progressing national health reform

There are immediate steps we can take to progress national health reform, particularly through the negotiations of the new national healthcare agreement.

Immediate action on these first, important steps will ultimately give all players the time and necessary momentum to keep a focus on the longer-term agenda for national reform. A key leadership body in this longer-term process will be the NH&HRC.

### **The Council of Australian Governments**

As an equal partnership of Australian governments, COAG will continue to be a key decision-making body and have a pivotal role in agreeing national reform proposals. COAG has established the Health and Ageing Working Group which will be instrumental in negotiating the respective roles and responsibilities of Commonwealth, State and Territory governments, and associated funding arrangements.

States and Territories will continue to use the Council for the Australian Federation (CAF) to build consensus positions on matters of significance in health reform, in consultation with Ministers for Health.

### **The National Health and Hospitals Reform Commission**

The NH&HRC is intended to be a time-limited body. It will play a crucial role as a broader forum for consideration of perspectives from business, community, non-government organisations and citizens in developing a shared, long-term national health reform action plan. To do so, and to provide valuable advice to decision-making bodies such as COAG, the NH&HRC must be independent and bipartisan.

Ultimately, realistic goals for what the NH&HRC could be expected to achieve in its timeframe are needed. A key role will therefore be for the body to recommend the long-term mechanisms required to enable a process of ongoing, dynamic change in this complex sector.

The Commission will report to the Commonwealth Minister for Health and Ageing, and through her to the Prime Minister, and to COAG and the Australian Health Ministers' Conference.

### **Ministers for Health**

Ministers for Health and their Departments will work closely with COAG and CAF to develop and implement the health reform agenda.

Maintaining progress in the right reform directions over the longer term will require both the whole-of-government focus of First Ministers and the detailed understanding of Health Ministers. There is an opportunity to input to the NH&HRC over the next 12 months and draw upon the expertise of officials in Departments of Health to identify additional reform opportunities, as well as to develop more detailed implementation plans.

## **7.3 Objectives and principles for implementing reform**

There are two clear, linked objectives underpinning this agenda that should continue to guide and focus any national health reform efforts.

### **Better health outcomes for Australians....**

The first objective is simply to deliver better health outcomes for all Australians, so that as many people as possible in our community can lead healthy and fulfilling lives. This must be the measure of all our reform efforts.

### **...delivered through a sustainable health system.**

The second objective is a health system for the long-term, that delivers better health outcomes for Australians in a sustainable and fair way. This underpins all our reform efforts; without it, we won't be able to achieve our goals.

These objectives in turn give rise to a number of principles for all parties to adopt in implementing reform:

- › **Collaboration:** We need ongoing constructive collaboration, and timely, effective dialogue between all those who care about the health of Australians. This means all levels of government, business, non-government organisations, communities, and individuals. Governments in particular need to commit to cooperative federalism that can drive important and much-needed change.
- › **Community engagement:** The voices of Australians themselves have long been overlooked in debates about our health system, and yet are fundamental to deciding what kind of health system our society wants for the future. We need to commit to ongoing community engagement as a key principle in guiding national health reform.
- › **A focus on outcomes:** We have outlined clear objectives for national health reform. To make sure we are achieving them, we need to define outcomes for all our reform efforts against our objectives, and commit to monitoring of our progress against those outcomes.
- › **Accountability and transparency:** Progress against the reform agenda must be independently assessed and transparently reported to all Australians.

## 7.4 Measuring progress

To deliver the health outcomes all Australians need, progress against a national agenda for health reform must be independently assessed and transparently reported.

For each of the four health goals, the agenda outlines clear goals and outcomes for our health system. We need to measure our progress in improving real health outcomes for Australians against this framework. Indicative indicators against which progress will be measured are presented, and more work will be done to refine and expand these over time.

# THE WAY FORWARD

This report demonstrates that a new approach to national health reform is timely, necessary and entirely achievable. It identifies four clear goals for health care for Australians that are based on a common understanding of the fundamental importance of good health to Australians and their communities.

A clear framework to help us achieve those goals is proposed, based on the identified challenges and agreed reform directions. Such long-overdue reform won't happen overnight, but this framework sets out the means for both short- and long-term progress towards our goals, with proposals that the Commonwealth and the States and Territories could agree to immediately, as well as proposals for further consideration by the National Health and Hospitals Reform Commission.

The cornerstone of this approach is one of partnership and shared responsibility. Governments must lead the way, and this report is the first step towards a new era of cooperation and coordination in inter-jurisdictional relations on health. However, in the end, effective reform will depend on a shared commitment from all Australian governments, and between government, community and private sectors. We need to recognise that we all have a shared goal and responsibility for the health of all Australians. This relies on:

- › All governments agreeing on a practical framework for national health reform, and a timetable for measurable progress.
- › All sectors – government, community and private – to embrace the need for reform and commit new resources to investing in Australians' health.
- › Individuals doing what they can and utilising all support available to them to maintain their own health and wellbeing.

**In the coming months, we will be actively progressing this Reform's agenda through COAG, Health Ministers, and the National Health and Hospitals Reform Commission. We value the input of the Australian community as we embark on this shared ambition to reform our health system for the future.**



