



National Health and Hospital Reform Commission: Summary of Final Report – July 09

Tackling major access and equity issues

Aboriginal and Torres Strait Islander Health

- All funding for Aboriginal and Torres Strait Islander people to be aggregated and the creation of a new body – National Aboriginal and Torres Strait Islander Health Authority (NATSIHA) – to control the funding to purchase or commission appropriate health services
- NATSIHA to have authority to demand and hold other health services to account for Aboriginal and Torres Strait Islander service provision – spending by these services matches the greater health needs.
- Integrated package to improve nutrition in targeted remote Aboriginal communities
- Train and recognise the Aboriginal health workforce and a workforce for Aboriginal health, including up-skilling the current workforce to provide culturally appropriate services.

People with a Serious Mental Illness

- Expansion of sub-acute mental health services
- Provide a rapid-response outreach team, 24hrs, to provide intensive community treatment and support

People Living in Rural and Remote Areas

- Provided with top-up funding to an equivalent amount of funding on a per-capita basis as communities with better access to medical, pharmaceutical and primary health care
- Increased funding for patient travel and accommodation
- Strategies to improve health workforce supply
- Clinical training opportunities in remote and rural areas

Improved Access to Dental Health Care

- Denticare: provide choice of getting basic dental care - prevention, restoration, and the provision of dentures – paid for via either a private health insurance plan or through public dental services.
- Internships for graduating dentists and oral health professionals (presuming in the public dental sector)
- National expansion of the preschool and school dental programs

Timely Access to Quality Care in Public Hospitals

- Public hospitals with major emergency departments are funded to ensure that beds are available at all times
- Extend the Commonwealth Government commitment to reducing waiting times (\$150m per annum until 2010-2011)
- Extra funding to reduce unmet need once the current lists are cleared

National Access Targets

- Implemented across all health services – including primary health care services, mental health services, aged care assessment, public hospital outpatient services, radiotherapy, planned surgery and emergency departments.
- Developed through broad community consultation

Re-designing the Health System to Meet emerging Challenges

Early Intervention and Prevention

- Embed early intervention and prevention into the health system and people's lives
- Establish a National Health Promotion and Prevention Agency to drive this shift through education, evidence and research
- Healthy start to life to ensure that children parents and potential parents have access to the right mix of universal and targeted services, targeting health and social needs
- Good mental health in young people through the implementation of youth-friendly community based services providing information and screening for mental disorders and sexual health, and specialist clinical services for prevention of, and intervention for early psychosis.

Connect and Integrate Health and Aged Care Services

- Strengthen primary health care services in the community as the 'first contact' point and for providing the majority of health care
- Integrating multidisciplinary primary health care services under the funding and policy control of the Commonwealth Government
- Establish Comprehensive Primary Health Care Centres and Services with extended hours
- Health Care Home that coordinates, guides and navigates access to multidisciplinary health services for people with complex health problems - including people with chronic diseases and disabilities, families with young children, and Aboriginal and Torres Strait Islander people – (people would have to voluntarily enrol in this program)
- Establish Primary Health Care Organisations for better service coordination and population health planning – to replace the Divisions of GPs
- Promoting better use of specialists in the community – expand speciality services in the community
- Separate the provision of elective and emergency services in public hospitals
- Review public hospital outpatient services so that they are aligned with patient needs and increased provision of these services in the community and not in hospitals

- Substantial investment in and expansion of sub-acute services, including a major boost to capital
- Additional investment in palliative care services for better access to care for people at home
- Aged Care Services – greater choice and responsiveness; effective use of public monies and protecting older people most in need; foster a robust and sustainable aged care sector

Next Generation of Medicare

- Commonwealth to bring together state funded primary health care services and medical services to create a comprehensive primary health care platform. This will include a focus on promoting good health, early intervention and better managing chronic disease.
- Consider the scope of services included under Medicare as a 'universal service entitlement'. This could be funded through a mix of salary, fee-for-service, grants, payments for performance and quality, and payments for episodes of care.
- Review the scope and structure of the existing safety net arrangements and simply the number of 'nets' and programs
- Reshape the Medicare Benefits Schedule once the scope of services has been decided. A framework is then needed to define the competency and scope of practice within which health professionals can provide certain services.

Creating an Agile and Self-Improving Health System

Strengthened Consumer Engagement and Voice

- Build health literacy
- Foster community participation
- Empower consumers to make fully informed decisions

Modern, Learning and Supported Workforce

- Foster clinical leadership and governance, including establishing clinical senates
- Develop a framework for the education and training of health professionals, which moves towards a flexible, multi-disciplinary approach, and incorporates an agreed competency-based framework as part of a broad teaching and learning curriculum
- Create a dedicated funding stream for clinical placements, undergraduate and post graduate
- Establish a National Clinical Education and Training Agency to advise on the education and training requirements; purchase clinical education placements; promote innovation; foster local implementation models; and report regularly on the appropriateness of professional accreditation standards.

Smart Use of Data, Information and Communication

- Introduce a person controlled e-health record for every Australian
- Commonwealth Government to legislate to ensure the privacy and security of a person's e-health data

- Make broadband and telecommunication networks available for all Australians to ensure these recommendations are successful
- Move clinicians and health care providers to electronic systems
- Governments to expedite an agreement on implementing a National Action Plan for e-Health, with set actions and due dates
- Development of Healthy Australia Goals 2020, first in a series of rolling 10 year goals, set by all Australians
- Health Performance Reporting that includes:
 - systems to provide comparative clinical performance data back to health services and hospitals, clinical units and clinicians;
 - publicly available information on health services to assist consumers in making informed choices;
 - the Australian Commission on Safety and Quality in Health Care to analyse, report and advocate on safety and quality across all health settings;
 - regular reporting on our progress as a nation in tackling health inequity.

Well-Designed Funding and Strategic Purchasing

- Creation of blended funding models so that in the future primary health care would receive funding that comprises ongoing fee-for-service payments, grant payments to support multidisciplinary clinical services and care coordination, outcomes payments to reward good performance, and episodic or bundled payments.
- Development of episodic payments
- Develop activity-based funding for hospitals using case-mix classifications – payments made on the basis of ‘outputs’

Knowledge-Led Continuous Improvement, Innovation and Research

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

Reforming Governance

Healthy Australia Accord

- Agreed and complementary roles and responsibilities of all governments in improving health services and outcomes – but maintaining a shared responsibility
- Defining a range of functions to be led and governed at the national level to ensure a consistent approach to major governance issues, such as workforce planning and education, and e-health;
- Realigning the roles and responsibilities of the Commonwealth and state governments, with the Commonwealth having full policy and government funding responsibility for primary health care, basic dental care and aged care, as well as

responsibility for purchasing health services for Aboriginal and Torres Strait Islander people;

- Commonwealth Government paying the state governments activity-based benefits for public hospital care and other public health care services (The assumption of greater funding responsibility by the Commonwealth Government would be met through commensurate reductions in Commonwealth grants or other funding to state governments.)
 - Commonwealth Government would pay 100 per cent of the efficient cost of public hospital outpatient services with an agreed, capped activity-based budget; and 40 per cent of the efficient cost of every public patient admission to a hospital, sub-acute or mental health care facility and every attendance at a public hospital emergency department.
 - Opportunity for this to increase to 100% of the cost for these services resulting in almost total responsibility for funding all public health services

‘Medicare Select’

- Health and hospital plans –
 - All Australians would automatically belong to a government operated health and hospital plan, which could be a national plan or a plan operated by a state government.
 - People could readily select to move to another health and hospital plan, which could be another government operated plan, or a plan operated by a not-for-profit or private enterprise.
 - Similar to Medicare now, health and hospital plans would cover a mandatory set of health services made explicit in a universal service obligation, which would include hospital and medical care and pharmaceuticals.
 - Funded by Commonwealth Government
 - Contracted through public and private providers to purchase services to meet the health needs of their members
- Over next two years Commonwealth Government commits to exploring the design, benefits, risks, and feasibility around the potential implementation of ‘Medicare Select’.

Implementing and funding reform

Roadmap for reform

- Council of Australian Governments (COAG) to agree in 2009 to develop the new Healthy Australia Accord to be agreed to in 2010.
- As an indicative estimate, the full year annual recurrent costs of implementing the reforms to Australia’s health system are between \$2.8 billion and \$5.7 billion. In addition, an investment in capital over five years of between \$4.3 billion and \$7.3 billion would be required to transform the system’s infrastructure
- ‘Denticare Australia’ would transfer to the Commonwealth Government responsibility for funding of \$3.6 billion per year, which is currently spent privately

through private health insurance or directly by consumers - offset by an increase in the Medicare levy of about 0.75 per cent of taxable income.