For debate

Pre-election series

Are we there yet? A journey of health reform in Australia

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Summary

- Five years on from the establishment of the National Health and Hospitals Reform Commission, it is timely to review the context for reform and some of the actions taken to date, and to highlight remaining areas of concern and priority.
- The Commission's final report was released in July 2009 and presented 123 recommendations organised under four reform themes:
  - ➢ Taking responsibility: individual and collective action to build good health and wellbeing — by people, families, communities, health professionals, employers, health funders and governments
  - ➢ Connecting care: comprehensive care for people over their lifetime
  - ➢ Facing inequities: recognise and tackle the causes and impacts of health inequities
  - ➢ Driving quality performance: leadership and systems to achieve best use of people, resources and evolving knowledge.
- Overall, the Australian Government's response to the Commission's report has been very positive, but challenges remain in some key areas:
  - ➢ Financial sustainability and the vertical fiscal imbalance between the federal and state governments
  - ➢ Getting the best value from the health dollar by reducing inefficiency and waste and using value-based purchasing across the public and private health sectors
  - ➢ National leadership across the system as a whole
  - ➢ Getting the right care in the right place at the right time
  - ➢ Health is about more than health care — increasing focus on prevention and recognising and tackling the broader social determinants of health.

Five years on from the establishment of the National Health and Hospitals Reform Commission in March 2008, it is timely to review progress. Here, I provide a reminder of the context for reform, a high-level summary of some of the actions taken to date, and some personal reflections and commentary highlighting areas of concern and priority as we continue our reform journey. In presenting this commentary, I hope to pull together the big picture and raise the profile of the many actions underway, some of which are not much in the public eye. A more comprehensive monograph was recently published for the University of Notre Dame Australia College of Medicine Health Leadership Series.[1]

The context for reform

In the lead-up to the 2007 federal election, the Australian health system was in crisis. Pressure on public hospitals, quality and safety issues, and poor morale in the health workforce were combined with a "blame game" of finger pointing between federal and state governments. There was public confusion about who was in charge. Community concern was on the rise,[2] and the momentum for reform was palpable, with an unprecedented readiness for change across the system and the community.

Enter Kevin Rudd with a bold promise to fix the health system and, "if by the middle of 2009 the State and Territory [governments] have not begun implementing a national reform plan, [to] seek a mandate from the Australian people … for the Commonwealth to assume full funding responsibility for the nation's public hospitals".[3] The compelling appeal of this commitment was soon put to the test.

In announcing the establishment of the National Health and Hospitals Reform Commission in February 2008, the new Prime Minister said that Australia's health system needed reform to meet "the long term challenges in our system: duplication, overlap, cost shift, blame shift, ageing population, the explosion in chronic diseases, not to mention, long term workforce planning".[4] Ten independent Commissioners with diverse expertise, experience and perspectives were appointed, and the work of the Commission began. After 16 months and arguably the most extensive consultation process ever mounted in health policy development in Australia, my colleagues and I delivered our final report.[5]

The report, released by Prime Minister Rudd in July 2009,[6] presented 123 recommendations organised under four themes, each a message of reform:

- *Taking responsibility*: individual and collective action to build good health and wellbeing — by people, families, communities, health professionals, employers, health funders and governments
- *Connecting care*: comprehensive care for people over their lifetime
- *Facing inequities*: recognise and tackle the causes and impacts of health inequities

- *Driving quality performance*: leadership and systems to achieve best use of people, resources and evolving knowledge.[5]

Reform action update

In March 2010, the Australian Government released its plan for a National Health and Hospitals Network.[7] This was followed in April 2010 by the signing of the National Health and Hospitals Network Agreement between the federal government and, except for Western Australia, all state and territory governments.

In a changing political landscape, the Australian Government's response to the Commission's blueprint for reform has seen some shifts in direction, particularly in relation to the reshaping of federal and state roles and responsibilities. A centrepiece of the 2010 National Health and Hospitals Network plan was a shift of financing responsibility that would see the federal government take full public funding responsibility for primary health care and majority funding responsibility for public hospitals, paying a 60% share of the cost using an efficient activity-based funding approach. In the subsequent National Health Reform Agreement, ultimately signed by all First Ministers in 2011 and currently being implemented, the federal government does not take responsibility for primary health care. It will, however, provide increasing funding to public hospitals, with a 45% share of the growth using an efficiently priced, activity-based funding approach from the 2014–15 financial year, and a 50% share of growth from 2017–18.[1]

Overall, the Australian Government's response to the Commission's report has been very positive. Of the 123 recommendations, 48 were agreed to, 45 supported, 29 noted, and only one was not supported.[8] My review of progress to date suggests that 44 recommendations are being actioned as proposed, 61 have been amended or partly implemented, and 17 have not yet been actioned. Some of the key reforms currently being implemented are described below under the Commission's reform themes.

Taking responsibility

An important and much anticipated initiative was the establishment in 2011 of the Australian National Preventive Health Agency to target effective prevention of obesity, tobacco use and harmful use of alcohol. This focus on prevention recognises that there is more to good health than health care, and that prevention and health risk management are vital contributors. Further investment and collaborative action are required to promote a healthy Australia.

The development of the MyHospitals website (http://www.myhospitals.gov.au) in 2011 and publication of Healthy Communities reports[9] in 2013 are part of new structures for public reporting on health system performance and health status to inform consumer choices and community action and policy. We are yet to see effective systems that provide feedback to individual clinicians and teams on their practice and outcomes compared with best-practice benchmarks and peers.

Introduction of the personally controlled electronic health record is underway, with registration available to individuals through http://www.ehealth.gov.au from 1 July 2012. Further system enablement and increased engagement and participation of medical practitioners are required ahead of a more comprehensive uptake and adoption strategy. Registrations reached 600 000 by 1 August 2013.

Connecting care

Strengthening primary health care has been a reform priority, with the establishment across Australia of 61 primary health care organisations — Medicare Locals — to support preventive action in local communities and more coordinated care for chronic disease, and to connect health care across settings, particularly with hospitals and mental health and aged care services.

Stronger devolution of governance to local hospital networks has been implemented by each state as part of the National Health Reform Agreement. More than 55 substantial local hospital networks have been formed, with some smaller networks in rural areas. Boundaries of Medicare Locals and local hospital networks are generally well aligned in most states, which should assist local planning, service collaboration and sharing of resources.

The Commission described subacute care services as the "missing link" in the continuum of health care. A key reform investment by the federal government has been to support development of subacute care, such as stroke recovery, rehabilitation services and palliative care, as part of a National Partnership Agreement with the states. However, funding is due to expire in June 2014.

End-of-life care and advance care planning initiatives are being explored, and aged care services reforms were the subject of a Productivity Commission inquiry.[10] While not embracing some of the fundamental reforms, the government is implementing recommendations to expand community and home-based care options and simplify the assessment process.

Facing inequities

The health of Aboriginal and Torres Strait Islander peoples is a focus of the national Closing the Gap strategy. However, the one recommendation of the Commission that was not supported by the government was the establishment of a National Aboriginal and Torres Strait Islander Authority,[5] which was proposed to perform an active health care purchasing role similar to what the Department of Veterans' Affairs does for veterans and their families.

Mental health care has received more attention with the creation of a National Mental Health Commission and significant new investment, and it has been given greater priority by most state governments.[11]

Dental health care has received an injection of funding to reduce public waiting lists. A more substantial investment to provide dental benefits to children in lower-income households has also been foreshadowed.[12]

Addressing inequity in access to health care for people living in rural and remote areas has led to initiatives such as strengthening of rural clinical schools to recruit and

1 Ideas for tackling inefficiency and waste

- Map unwarranted variations in health service delivery to help inform local analysis and action
- Support end-of-life care and advance care planning to help enable people's preferences to die at home instead of in hospital
- Address the inefficient allocation of care in hospital because of service gaps (eg, rehabilitation services, aged care and palliative care)
- Provide evidence portals to support use of best evidence in clinical practice
- Provide feedback to doctors on their own practice patterns and patient outcomes against best practice and their peers
- Support secondary prevention, such as falls prevention and management of osteoporosis after first fracture
- Reduce adverse drug events through a range of measures
- Use shared informed decision-making tools to help people decide whether they want a procedure, particularly when treatment choices and evidence are unclear
- Use evidence to disinvest in procedures and treatments that do not work
- Make better use of multidisciplinary team skills to increase productivity
- Minimise duplication and non-value-adding administrative processes
- Reduce unnecessary repeated pathology tests and imaging through better access to results from other sources
- Use smart purchasing for value (ie, funding approaches that pay for performance and outcomes) ◆

train doctors in rural areas, development of multipurpose centres and telehealth services.

The National Disability Insurance Scheme is an important health and social justice initiative for people living with disabilities, and their carers. This welcome development requires further detail on its financing and scope.

Driving quality performance

A new transparent, nationally consistent approach to federal financing of public hospital services by efficient activity-based funding is a major element of the reforms. Greater clarity of the Australian Government contribution to the growing costs of public hospitals is also important to the financial sustainability of state health systems, although it remains unclear whether the ultimate federal government share will adequately address the vertical fiscal imbalance between state and federal governments.

To support the new arrangements, two independent national bodies have been formed: the Independent Hospital Pricing Authority, which is determining the national efficient pricing for public hospital service activity; and the National Health Performance Authority, which reports on around 50 measures across the health care continuum through Hospital Performance and Healthy Communities reports.

Health Workforce Australia has provided a platform for a national, coordinated approach to health workforce planning, training and innovation. Meeting the demands for training places across the system, including postgraduate and advanced training, is a national challenge currently being explored in the public and private sectors and various health settings. Strengthening involvement of universities, vocational training organisations and professional colleges, as well as the private sector, would be valuable.

Knowledge management systems, smart use of health information through data linkage, and analysis of patterns of health service use and unwarranted variation are receiving some limited attention. The Commission's recommendation to link data from the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and public and private hospitals[5] has still not been implemented. Further investment will be vital to reduce waste and inefficiency and increase quality and equity in health care, and will be greatly aided by health systems research to support local and systemic solutions.

The government's response to the recent McKeon review on health and medical research[13] is pending. More than ever in this era of active reform, it is crucial that research is recognised as an integral element of what our health system produces and not just a bolt-on activity. Active involvement in research across clinical settings requires investment, support systems and a cultural shift. More effectively translating evidence into clinical practice and health policy requires focus, and robust evaluation of the outcomes of reforms and health system performance is a priority.

Challenges ahead

Even with this extensive and complex package of reforms, major challenges remain. Nations around the world are grappling with four issues in particular:

- financial sustainability — tackling waste and inefficiency in health care in a systemic way, as well as innovating to get value-based purchasing into how we pay for health activity;
- coordinating and connecting care for patients across service settings and over time;
- how to best leverage the benefits of public and private health financing and care provision; and
- changing lifestyles, the rise of non-communicable diseases and the broader social determinants of health.

Financial sustainability and vertical fiscal imbalance

Sustainability of health financing, the vertical fiscal imbalance and the re-emergence of the blame game cannot be ignored. I would like to see the governments of Australia revisit the original proposition in the 2010 National Health and Hospitals Network plan — that the federal government takes full public funding responsibility for primary health care and community-based care and 60% of public hospital funding on an efficient activity basis.

Alternatively, the federal government's share of growth under activity-based funding of public hospitals and health services could be increased to 60% from now and include a broad range of out-of-hospital services in its scope. This would avoid the need for negotiations on the goods and services tax or other financial adjustments, and would shift to an increased forward exposure to the federal government for public hospital care, similar to the level originally planned.

Tackling the vertical fiscal imbalance will not solve all the health system's problems, but it would remove a major distraction and point of tension that fuels the blame game.

2 Five steps to get the right care at the right place at the right time

- Better define appropriate care, in terms of both clinical evidence and explicitly seeking a person's preferences and informed decisions
- Fill service gaps, such as rehabilitation, palliative care, specialist teams in the community, home-based care and aged care services
- Support people to navigate the system through a "health care home" as their core relationship from which care is coordinated, and with online tools and resources and telephone health coaching and advisory services
- Connect care through better communication between patients, carers (where relevant) and health care providers, including innovations such as personally controlled electronic health records, apps and telehealth
- Use smart purchasing to support appropriate care in the best setting and over time (eg, bundled packages and episodes of care across providers, with an outcome focus ◆

Getting the best value from the health dollar

There is inefficiency in our health system at many levels. Waste in health care is both an ethical and an economic issue. Introducing efficient activity-based funding of public hospitals does not in and of itself deliver efficiency, but it will be a useful tool. Hospitals also require access to analytical capability, change management skills and, in some instances, capital and technology investment. Additional ideas to improve efficiency are presented in Box 1.

Effective national leadership across the system

National leadership across the system as a whole remains a structural challenge. One idea is to form an expert reference body, independent of jurisdictions and health departments, with members offering clinical, economic and community perspectives to inform, advise, monitor and publicly communicate on progress toward agreed outcomes. This could be a constructive watchdog or advisory health assembly.

Moving to a single national public funder model with a national health authority responsible to the Council of Australian Governments could provide a system-wide approach that builds on the strengths of a national funder and purchaser. This is not to say that the federal government would be the sole funder (federal and state contributions could be pooled), nor that the federal government would manage the public hospital system (state governments would continue to operate public hospitals with transparent activity-based funding, and private hospitals could add competition for funding of public patient care). The independent national body could be an active purchaser across the continuum of services, building on the platform of activity-based funding and exploring more innovative purchasing over time. In the meantime, we could further explore "Medicare Select", as recommended by the Commission, where greater consumer choice, competition and innovation in purchasing may also enable better use of our mixed system of public and private financing and provision.[5]

The right care in the right place at the right time

The challenge of delivering the right care in the right place at the right time in a coordinated way is a challenge all health care systems face. Whatever the financing system — whether a single funder (eg, the United Kingdom's National Health Service), social insurance models (eg, in France and Germany) or a private insurance system (eg, in the United States) — all still struggle with achieving connected care across the continuum. As such, while moving to a single public funder model may reduce fragmentation, give a whole-of-system view and potentially enable greater financing innovation, it does not guarantee it.

In addition to more innovative approaches to health funding, there are five steps that we need to take to get the right care at the right place at the right time (Box 2).

Health is about more than health care

Good health is about more than good health care. Many other factors influence our health — our biology, lifestyles and behaviour, the environment we live in, and social, economic and cultural factors. We need to get more serious about prevention. As with tobacco products, a package of actions is required — from education, social marketing and behavioural change through to regulation and taxation measures. It requires time, investment and the involvement and collaboration of many parts of government, the health system and society. It must be evidence-led where possible, and new initiatives must be actively evaluated.

It is unacceptable to walk away from personal and shared responsibility. We should each have the starring role in our own health and health care decisions. However, inequities mean we do not all have the same life experiences and opportunities. Health literacy, educational attainment, employment, stable housing and many other factors may affect our capacity to make healthy choices. If we are serious about the good health of Australians, we must be serious about making healthy choices easier and fairly available.

In addition to health service reform, there is a serious need for a national action plan that crosses governments and portfolios to address factors in the social environment that affect health status.

Conclusion

Health needs to be a live issue on the national agenda. While there has been some valuable progress, we have not yet resolved the structural flaws in funding and governance that fragment health care delivery in Australia. We have focused largely on public health financing and public hospitals but have not yet considered innovative approaches, such as Medicare Select, to better use the private sector.

We have a long way yet to go on our reform journey, and we need political leadership and strong engagement with the health sector and community as we continue to move towards a sustainable, high-quality and responsive health system for all Australians.

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