

CHAPTER 7

IMPLEMENTING A NATIONAL PLAN FOR HEALTH REFORM



7. Implementing a national plan for health reform

“ There is no shortage of excellent health policies in the Australian health system – the problem is implementation, not policy.²²² ”

7.1 Committing to health reform

The task of implementing major reform of Australia’s health system may seem daunting. But it is worth recalling that the Commonwealth Government implemented Medicare in less than two years and the Victorian Government implemented activity-based funding for public hospitals in just five months. In both cases, the governments had a strong commitment to reform in the face of an urgent need for action. We have argued in this report that Australia again faces an urgent need for reform of our health system. Our health care system is under pressure from many quarters:

- significant increases in demand for, and expenditure on, health care due to many factors, including advances in medical technology, an ageing population, the increase in chronic disease, and the increase in consumer expectations;
- unacceptable inequities in health outcomes, particularly the gap in health outcomes for Aboriginal and Torres Strait Islander people;
- lack of access to health services for many people, particularly people with a mental illness, people in remote and rural Australia, and low-income people in need of dental care;
- growing concerns about quality and safety;
- problems with the availability, mix and distribution of the health workforce; and
- high levels of inefficiency, including administrative inefficiency (for example, business processes and bureaucracy), operational inefficiency (for example, poor use of data and information and medical errors), and allocative inefficiency (for example, inappropriate emphasis on acute care and lack of cost effectiveness of interventions).²²³

Addressing these pressures on the equity, efficiency and sustainability of our health system will require the leadership of all Australian governments. A clear message of our recommendations is that we need to move in many areas to ‘one health system’, with a national approach to many key policies and governance functions. To achieve reforms at a national level, leadership falls most squarely with the national government. But Australia does not have a single government with responsibility for health policy, programs and funding, and reform of health care will require the leadership and commitment of the states as well. That is why we see a new national health agreement – the Healthy Australia Accord – between the Commonwealth and state governments as fundamental to implementation of many of the reforms that are needed to give Australians the health system they deserve for the 21st century.

In this final chapter, we turn to these practical issues of leading and managing change, and consider an implementation plan for our recommended reforms, and the financial implications of, and gains from, our reform agenda.

7.2 Implementing reforms

Our reforms cover a wide range of initiatives of differing degrees of implementation difficulty – from increased funding for health services research and oral health promotion, to implementing a national e-health system and the Commonwealth Government taking full responsibility for primary health care. While we agree this is an ambitious reform agenda, we note that it is not unusual for the Commonwealth Government or a state government to pursue initiatives across many different areas simultaneously within a portfolio. Governments’ annual budget documents provide evidence of this.

222 N Argall (2008), Submission 366 to the National Health and Hospitals Reform Commission: First Round Submissions.

223 National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, at: www.nhhrc.org.au

Furthermore, there are clearly different types of initiatives within our reform agenda which allow different approaches to taking action. For the purposes of implementation, our reforms fall into three broad categories:

1. **Reforms which are essentially within the ambit of one level of government** – for example, reshaping the Medicare Benefits Schedule and expanding choice in aged care, both of which are the responsibility of the Commonwealth Government;
2. **Reforms which realign roles and responsibilities between the Commonwealth Government and the state governments**, such as the Commonwealth Government having full responsibility for the policy and government funding of primary health care and basic dental care. These reforms will be set out in the new Healthy Australia Accord; and
3. **Reforms which are longer term in nature** and require further investigation and/or development. These include the exploration of the design, benefits, risks and feasibility around the potential implementation of 'Medicare Select'.

Within these categories, there are some reforms that are dependant on others, and so need to be implemented sequentially. This is true of several of the reforms in aged care – for example, the alignment of subsidies and fees across community and residential care is a necessary precursor to allowing people greater choice as to whether to use their care subsidy at home or in a residential aged care service. Other initiatives are essentially stand-alone. Understanding the degree of connections between initiatives will help plan implementation.

In Appendix G, we have put forward a high level action plan which addresses key elements of implementation. As more detailed planning and implementation work is undertaken, there may be sound reasons for altering the plan. The plan:

- sets out for every recommendation our suggestions as to who should lead or instigate the reform, who should be responsible for doing it and, in some cases, the timing of reform;
- identifies those recommendations that require changes to government responsibilities and/or federal funding arrangements, as a guide to what will need to be addressed under the Healthy Australia Accord;
- identifies where legislative change may be required; and
- outlines in greater detail some of the areas of reform where staging of action is required.

Generally, in terms of timing, we believe that – wherever possible – steps should be taken to commence development and take action on each reform or set of reforms in the first year. Implementation should be regarded as commencing with government endorsement of reform. Furthermore, we believe that most of the reforms we have proposed in categories 1 and 2 – that is, reforms which are either essentially within the ambit of one level of government (category 1), or which realign roles and responsibilities between the Commonwealth Government and the state governments (category 2) – could be substantially achieved within three to five years, with some able to be implemented sooner than this. Work to introduce most of those reforms which are within the ambit of one level of government could also commence immediately.

7.2.1 Leading reform

To give effect to a national health system, we are calling on First Ministers to agree to a new Healthy Australia Accord that will clearly articulate the agreed and complementary roles and responsibilities of all governments in improving health services and outcomes for all Australians.

The first step towards this should be for the Council of Australian Governments (COAG) to agree in 2009 to develop the new Healthy Australia Accord – consistent with our recommendations in Chapter 6. The aim should be to agree the Healthy Australia Accord in 2010. To accelerate the pace of reform, one option would be for the Accord to be a high level agreement, supported by more detailed individual agreements on specific reform elements. This would allow early action on some reforms while others were still being developed.

In parallel, we recommend that over the next two years the Commonwealth Government explores the concept of 'Medicare Select' including the design, benefits, risks and feasibility of introducing 'health and hospital' plans.

From our experience over the past 16 months, we are certain that there is a genuine desire for reform of Australia's health system. Our existence as a Commission, and the endorsement of our terms of reference by all governments, demonstrates governments' acceptance that improvements to Australia's health system are needed. Moreover, based on our consultations both in meetings and through the submissions we have received, we know the community, health professionals and health services are also ready to embrace reform.

We urge governments to continue consultation and engagement with the community, health professionals and health services – successful implementation of the reform agenda will depend upon it. Change is more easily achieved, and with better results, when it is informed by the views and with the active involvement of those affected.

7.3 Accountability for reform

Accountability is also critical to successful change. Many of the reforms we have proposed are intended to clarify and strengthen accountability for the performance of the health system and of health services. This is true of our proposals to change the allocation of responsibilities between governments; to improve measurement of service performance, with funding to be increasingly linked to performance; and to improve public reporting of quality and performance at the service and the system level.

We believe there must also be clear accountability for implementation of reform. For many of our reforms, the Healthy Australia Accord provides a basis for this at the highest level – heads of governments. Progress of the reforms in the Healthy Australia Accord should be monitored and publicly reported by the COAG Reform Council – the independent agency established by the Council of Australian Governments to monitor and report on the performance of governments against national reform agreements. For our recommended reforms that do not require an inter-government agreement, we urge the responsible government or governments to set out a timeframe for their implementation and commit to reporting against this. In addition, we propose that the Commonwealth Government draw on a national Clinical Senate (see Section 5.2.1) to provide continuing advice on the implementation of reform and appropriate measures of performance and outcomes. However, accountability must go beyond ensuring adherence to the implementation of agreed reforms within a specified timeframe. Ticking off an agreed list of reforms as they are implemented is not sufficient.

The real measure of success will be a demonstrably better health system, both in a technical sense – such as improved access to health services – and according to those who rely on it and those who work within it. That is why we believe that there should be three measures of success of our health system: measures of the performance of the health services, of the public's confidence in the health system, and of the satisfaction of those working within it.

Performance against these three measures should be regularly monitored and publicly reported. Reporting should be at the national, state and local service level. Reporting should also reflect how well the health system meets the needs of the most vulnerable people and those hardest to reach, including people living in rural and remote areas, the socially and economically disadvantaged, and Aboriginal and Torres Strait Islander people.

Transparency is linked to accountability. Many people mistakenly believe that the Medicare levy of 1.5 per cent of taxable income funds total Commonwealth expenditure on health care. But in fact it represents about 18 per cent of the Commonwealth's total spending on health care, and only about 8 per cent of the total spending on health care from all sources including by governments, through private health insurance and directly by us as individuals.²²⁴ As we discussed in Section 4.3.3, being open and clear about how much it costs to have access to universal health services would help create greater transparency and community understanding about spending on health.

224 Commonwealth Government (2007), Budget Paper No. 1, Budget Strategy and Outlook 2007-08, Statement 5: Revenue, p. 5-9; Australian Institute of Health and Welfare (2008), Health Expenditure Australia 2006-07, p. 20 (Australian Institute of Health and Welfare: Canberra).

7.4 Investing in reform – assessing the financial implications

This section considers the financial implications of our proposed initiatives – or, to put it another way – the investment required to achieve reform of Australia’s health system.

We consider the financial implications of our proposed reforms from three perspectives:

- the recurrent and capital costs of major reforms;
- the impact on health expenditure over the medium to long term; and
- the gains to efficiency and productivity.

7.4.1 Recurrent and capital costs of major reforms

We have estimated the indicative costing of those of our reforms that entail significant additional expenditure (see Appendix H). The additional costs in a full year of these reforms to Australia’s health system (excluding ‘Dentcare Australia’) are between \$2.8 billion and \$5.7 billion (see Table 7.1).

These figures include indicative costs for improved public dental care, but not for the ‘Dentcare Australia’ scheme which is considered separately. Once fully implemented, ‘Dentcare Australia’ would see the transfer to the Commonwealth Government of responsibility for funding of \$3.6 billion per year, which is currently spent privately through private health insurance or directly by consumers. We have suggested this, and an increase in spending to meet unmet need, could be offset by an increase in the Medicare levy of about 0.75 per cent of taxable income. Many people would pay less for dental care under ‘Dentcare Australia’.

In addition, an investment in capital over five years of between \$4.3 billion and \$7.3 billion would be required to transform the health system’s infrastructure to enable our reforms (see Table 7.2). Capital investment is a critical enabler of a number of our transformative reforms – including delivering an e-health agenda, strengthening primary health care, and reforming dental care. Capital can drive change and is fundamental to achieving the efficiencies and reorientation of the health care system we are recommending. Short term capital investment will be vital to reshaping how care is delivered, filling service gaps, building new systems and capabilities and stimulating change.

Appendix H sets out the basis for these estimates. We draw attention below to a number of important points in understanding the overall basis of our estimates:

- recurrent costs are indicative estimates of full year expenditure;
- some recommendations have no additional costs as governments have already committed to fund similar areas of focus. For example, COAG has agreed to fund a number of initiatives similar to those proposed under our Healthy Start strategy, and the Commonwealth Government has committed \$1.58 billion in funding for improved health services for Aboriginal and Torres Strait Islander people under the ‘Closing the Gap’ strategy;
- where we have recommended the continuation of an existing activity that has time limited funding – such as the Australian Commission on Safety and Quality in Health Care or the Elective Surgery Waiting List Reduction Plan – we have included the ongoing cost of the activity in our estimates of expenditure; and
- however, where the initiatives we have proposed differ from an existing or new function or service to which government has committed we have noted the additional costs. For example, our recommended National Health Promotion and Prevention Agency has a broader remit than that proposed by the government so we have estimated the additional funding required.

Table 7.1: Indicative costs of reform recommendations

Reforms	Range of costs (savings/revenue)	
	\$m	\$m
Prevention	100	100
National Health Promotion and Prevention Agency	100	100
Supporting healthy workers*		
Primary Health Care	883	1962
C'wth responsibility funding & policy primary health care#		
Enrolment of young families, Indigenous people, the chronically ill	341	682
PHC prevention, access and quality performance payments	252	800
Primary Health care organisations	150	150
Reshaping MBS	140	330
Targeted antenatal care*		
Core contacts for child & family health*		
Hospitals	(138)	917
National performance reporting & accountability framework	12	12
National activity-based hospital funding	(1330)	(570)
Nationals Access Targets and Hospitals/ED	720	1015
Enhanced sub-acute care services/aids and equipment	460	460
Aged Care	874	1323
Expanding provision of aged care subsidies	530	838
More flexible range of community aged care subsidies	296	437
Medical arrangements with residential aged care services	48	48
Advance care planning training		
Health and health care for Indigenous people	70	70
Aboriginal & Torres Strait Islander healthy nutrition funding	12	12
National Aboriginal & Torres Strait Islander Health Authority	58	58
Rural and remote	217	514
Equivalence funding in remote and rural areas	55	143
Remote & rural outreach, telehealth & advice networks	50	100
Rural workforce enhancement package	27	27
Patient travel assistance	85	244
Mental Health	356	356
Communities of youth services	30	30
Early psychosis prevention and intervention services	26	26
Rapid mental health response teams	200	200
Sub-acute mental health services	70	70
Employment support for people with mental illness	7	7
Mental health and dementia support for older Australians	23	23
Dental Care and Oral Health	320	320
Dental Residency program	200	200
School dental expansion	100	100
Oral health promotion	20	20
Workforce		
New clinical education and training framework*		
National education and training agency*		
National professional registration*		
Aboriginal & Torres Strait Islander health and professional training*		
Increasing training places in remote & rural areas*		

Table 7.1: Indicative costs of reform recommendations (continued)

Reforms	Range of costs (savings/revenue)	
	\$m	\$m
One national health system	167	167
Clinical, health services and health policy research	100	100
National health innovation	8	8
Australian Commission for Safety and Quality in Health Care	34	34
National health intervention & private hospital regulation	25	25
Total	2849	5729

* COAG funding noted

Entails shift of about \$4 billion from states to Commonwealth

Table 7.2: Estimated capital requirements (over 5 years)

Reforms	Range of costs (\$m)	
Primary Health Care		
Comprehensive PHC Centres and Services	300	300
Hospitals		
Enhanced sub-acute care services	900	1500
Hospitals reshaping	1250	2500
Mental Health		
Communities of youth services	30	30
Dental Care and Oral Health		
Dental residency program	375	750
School dental expansion	125	250
Workforce		
Clinical education & training facilities (across all settings and including rural)	100	150
One national health system		
National e-health agenda	1185	1865
Total	4265	7345

In considering these recurrent and capital implications of reform, it is important to note that this investment would be across both Commonwealth and state governments to varying extents for different reforms.

Also changes to the actual level of expenditure in any one year from our reforms will depend on the pace of the implementation of the reforms. If phased in over several years, as we anticipate, the impact on expenditure in any one year could be quite modest.

Furthermore, as set out later in this chapter, these indicative estimates of the recurrent costs of the specific recommendations do not take into account the potential of a number of the reforms to contain health expenditure and increase productivity, while improving people's health and providing a better, more effective mix of services. Overall, modelling by the Australian Institute of Health and Welfare indicates that elements of our proposed reforms will result in lower growth in health expenditure in the medium to long term.²²⁵

225 Australian Institute of Health and Welfare (2009), Estimates of the impact of selected NHHRC reforms on health care expenditure, 2003 to 2033, (AIHW: Canberra).

7.4.2 Gains from the investment

As for any investment, it is important to keep in mind what we are aiming to achieve.

Through this investment, we are aiming to transform the Australian health care system by:

- tackling the major access and equity issues that affect people now;
- redesigning our health system to meet emerging challenges; and
- creating an agile and self improving health system for the future.

Appendix H identifies the indicative costs of our major reforms. Here we highlight the gains from our investments:

- **prevention** would become a high priority, with education, evidence and research driven by the National Health Promotion and Prevention Agency;
- through support for the achievement of **National Access Targets**, people's timely access to public hospitals and health services would be improved across the care continuum – acute care, emergency care, specialist care, primary health care, community health services, aged care, and diagnostic services;
- **primary health care** would be embedded as the cornerstone of our health system, reinforcing prevention, early intervention, and connected care;
- young families, Aboriginal and Torres Strait Islander people, and people with complex and chronic needs would have a '**health care home**' through voluntary enrolment with a primary health care service;
- a **healthy start to life** for all children would be supported, through universal and targeted services;
- for the first time, **universal access to basic dental services** would be provided, addressing a key area of both health need and health inequity;
- for **people with a mental illness**, to improve their health and wellbeing and reduce the need for crisis care, the focus would shift to early intervention, better management of mental health disorders, and better support;
- the approach to funding of health services for **Aboriginal and Torres Strait Islander people** would be radically changed, to actively purchase and commission the very best care;
- improved services, support and equivalent funding for people in **remote and rural** Australia would be introduced, to redress a basic inequity in access to our 'universal' service entitlement;
- adequate, responsive **aged care services** would be ensured for the increasing numbers of older people;
- **hospitals of the future** would be created, specialist services in the community would be expanded, and sub-acute services – the 'missing link' – would be increased;
- the **education and training** – and continuing education – of our health professionals would be improved;
- a **national e-health agenda**, including a **person-controlled electronic health record**, would be delivered to enable people to take a more active role in managing their health and making informed health care decisions, improve clinical decision making, reduce medical errors, and improve productivity; and
- a 'self improving' health system would be driven by the establishment of a **permanent national safety and quality commission**, adequate funding for **research** – including health services, public health and health policy research – and the availability of '**smart data**' on **clinical quality and health system performance**.

While we have highlighted a number of major investments, it is important to emphasise that the level of expenditure is not necessarily a yardstick for the significance of a recommended reform. For example, transferring funding and policy responsibility for primary health care from the states to the Commonwealth Government does not require increases in expenditure. Over time, however, we believe it will enable the transformation of the delivery of primary health care, particularly through more comprehensive, better integrated and coordinated care.

7.4.3 The impact on health expenditure over the medium to long term

Estimating the increased government recurrent and capital expenditure is one way of assessing the financial implications of our reforms. But it has its limitations, focusing just on the immediate costs. It does not take full account of the improvements in performance and efficiency that will be achieved in the medium to longer term through better provision of more appropriate services as a result of the reforms. Assessing the value of the recommended reforms is more complex, requiring an understanding of their full costs and benefits over the medium to longer term.

To take one example: investing in a healthy start to life and strengthening primary health care as the foundation of our health care system are key strategies for both reorienting health care to wellness and prevention, and rebalancing and connecting care for people over their lifetime. This set of reforms will require significant expenditure, particularly due to the costs of additional services for families with young children, Aboriginal and Torres Strait Islander people, the chronically ill, and people with disabilities through voluntary enrolment.

But this is just the cost side of the balance sheet. This investment in primary health care will improve the health and wellbeing of many, many thousands of Australians. For example, better access to primary health care will mean reductions in obesity and smoking and earlier and better treatment of chronic diseases, such as diabetes. In the medium to longer term, these impacts will flow through to reductions in other diseases, particularly cardiovascular diseases, and hence reductions not only in mortality and morbidity but also in more expensive acute hospital care. Thus, in the medium to longer term, these reforms will reduce growth in projected health expenditure. Indeed, the Australian Institute of Health and Welfare (AIHW) has estimated that the introduction of patient enrolment with a primary health care service will save \$380 million a year by 2022–23 and \$635 million a year by 2032–33.²²⁶

While it is complex to attempt to fully assess the costs and benefits of investment, we believe it is important to do so to give people a more complete picture and understanding of the gains from the additional investment we are recommending.

To do this, we commissioned the AIHW to estimate the impacts of our key recommended reforms on health expenditure over the medium to long term. In summary, modelling by AIHW suggests our reforms would result in lower costs overall in the medium to longer term. The impacts considered were:

- strengthening of primary care services through patient enrolment;
- more sub-acute care and subsequent reduction over time in the proportion of hospital bed days which are for acute care;
- increase in aged care places;
- improved treatment of diabetes;
- reduced rate of increase in obesity rates;
- faster decline in smoking rates;
- implementation of 'Denticare Australia';
- implementation of personal electronic health records; and
- improvements in safety and quality of care.

The AIHW estimated the impacts of our key reforms on factors such as changes in disease rates, number and type of services received (for example, admitted or primary health care), and the proportion of people who receive treatment.

Table 7.3 compares the AIHW's current projections of health and residential aged care expenditure in 2022–23 and 2032–33 with the projected expenditure after taking account of the impacts of our key reforms. According to the AIHW, our key reforms will reduce projected spending by \$4 billion a year by 2032–33. As a proportion of GDP, health and aged care expenditure will be 12.2 per cent of GDP in 2032–33, which is less than the projected 12.4 per cent.

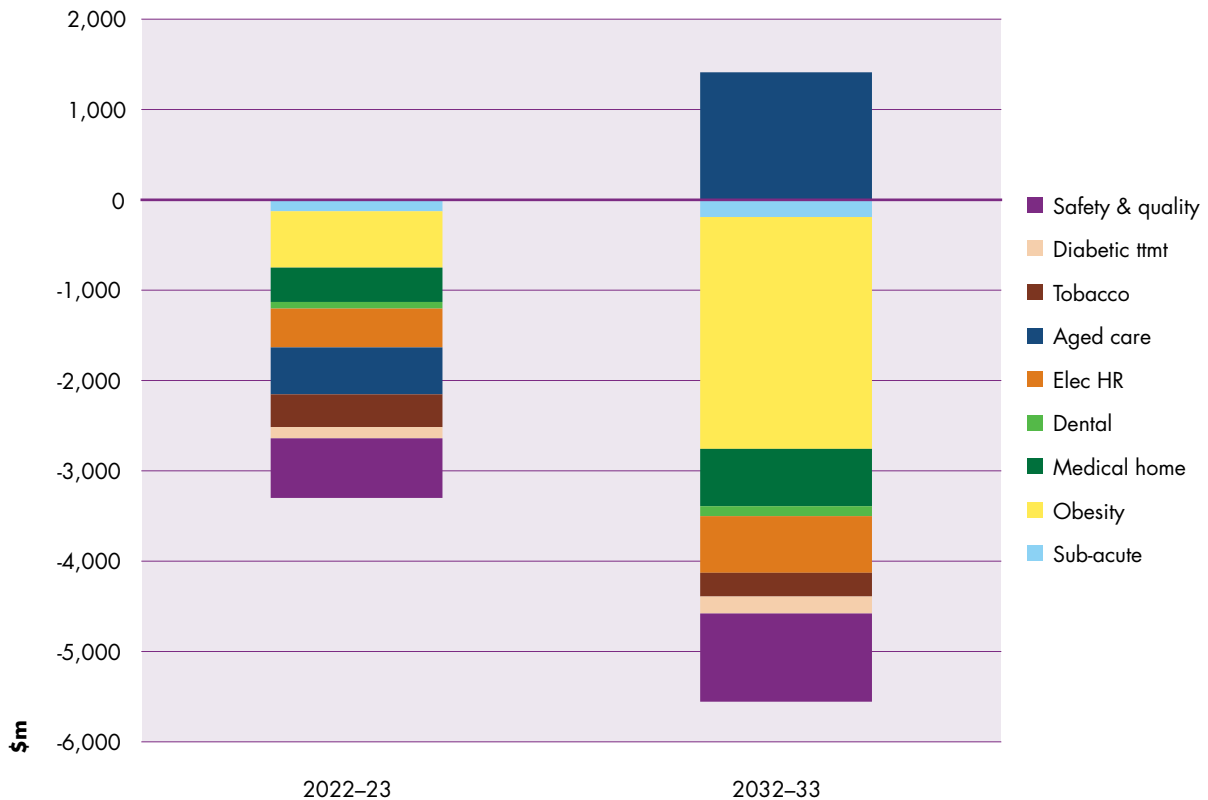
226 Australian Institute of Health and Welfare (2009), Estimates of the impact of selected NHHRC reforms on health care expenditure, 2003 to 2033, (AIHW: Canberra).

Table 7.3: Estimated changes in projected health and residential aged care expenditure due to reforms

	Expenditure (millions of 2006–07 dollars)		
	2002–03	2022–23	2032–33
Current projections of health & residential aged care expenditure (\$m)	85 063	167 729	246 056
Current projected expenditure as per cent of GDP	9.3%	10.6%	12.4%
Less net savings due to impact of reforms (\$m)			
<ul style="list-style-type: none"> • Improved availability of sub-acute care • Reduced rate of increase in obesity • Faster decline in smoking rates • Patient enrolment with a primary health care service • Reforms to aged care • Improved access to basic dental care • Improved treatment of diabetes • Implementation of personal electronic health records • Improved safety and quality of care 			
Total		-3 301	-4 142
Revised projections of health & residential aged care expenditure (\$m)	85 063	164 428	241 914
Revised projected expenditure as per cent of GDP	9.3%	10.4%	12.2%

Figure 7.1 shows these in graphical form.

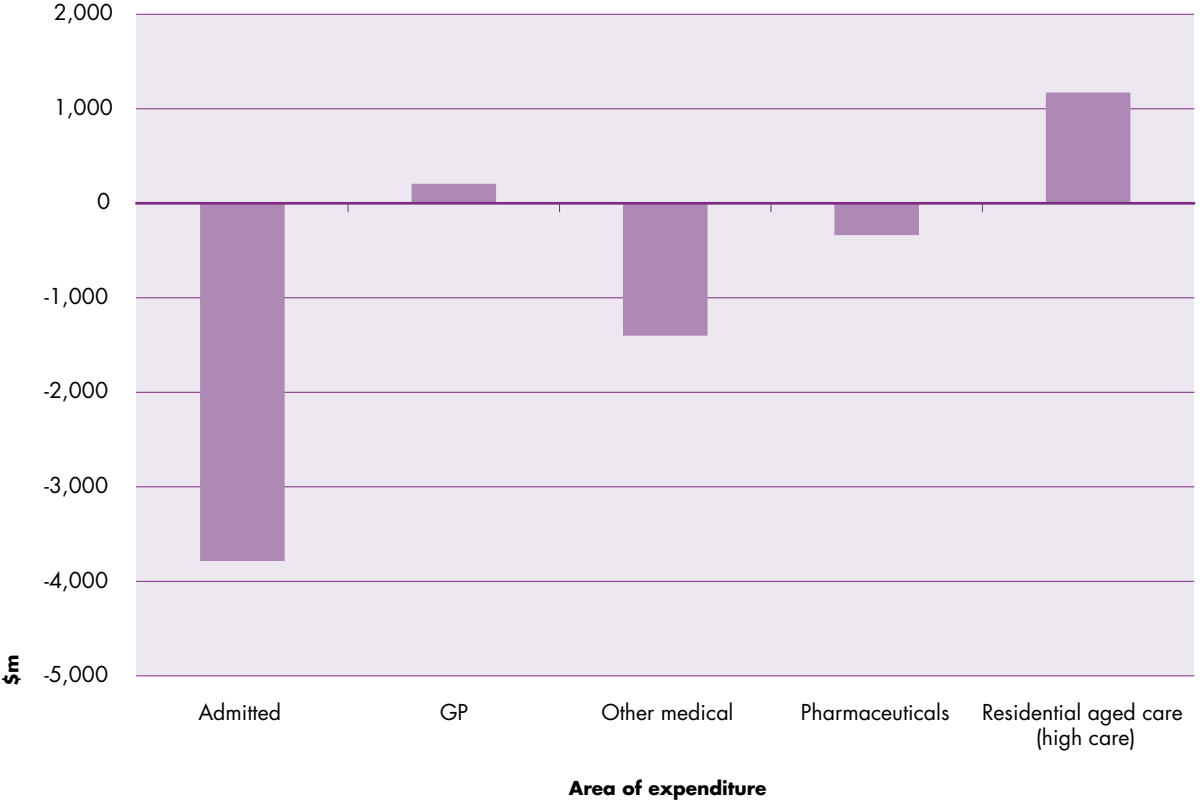
Figure 7.1: Estimated changes in total expenditure as a result of selected reforms, in 2022–23 and 2032–33, (\$ millions)



Looking behind the figures gives a better understanding of the estimated impacts of our reforms. Figure 7.2 illustrates the impacts of selected reforms on the balance of expenditure between services, showing, for example, that expenditure on primary medical care (GPs) and residential aged care are expected to increase as a result of our reforms, while expenditure on admitted patient care, other medical services (including specialist medical care outside hospitals) and pharmaceuticals will decrease, relative to projected spending in the absence of these reforms.

Overall, there is a shift in the balance of expenditure from admitted care to primary health care and/or residential aged care, improving the allocative efficiency of the health system.

Figure 7.2: Shifts in projected expenditure between services by 2032–33, flowing from aspects of our recommended reforms (\$m).



Overall, the AIHW’s analysis indicates that the net effect of our reforms would be to reduce the burden of disease and deliver a better mix of more accessible and effective services at a lower cost and higher productivity within (or under) the projected increase in expenditure that would occur without these reforms. In other words, investing in these reforms now will deliver greater value for the community in the future.

7.4.4 Gains to efficiency and productivity

Another way of assessing the financial implications of our reforms is to focus on the gains to efficiency. As the background paper on efficiency prepared for the Commission notes:

“ The efficiency of the health care system is important, not only because it is key to delivering an affordable and sustainable health system, but also because it can be an ethical issue in terms of equity and fairness. If waste occurs – whether through duplication, poor processes, unnecessary high cost inputs, errors, too much administration, spending on treatments that were not needed or unlikely to improve outcome or could have been provided with an equivalent or better outcome in a lower cost way – it will adversely impact other people’s access to health care in a system with finite financial, capital and human resources.²²⁷

We have proposed a number of reforms to improve the efficiency of the health system, notably:

- using **activity-based funding** to drive the efficient delivery of public hospitals, public health services and clinical education;
- using **economic assessments of the cost effectiveness of interventions** to ensure funding goes to those interventions that will deliver the best outcomes for a given level of resources;
- **performance-based payments** to encourage and reward best practice and high quality outcomes;
- a **rebalancing of the type of interventions** delivered so that fewer people become ill and to ensure that when people need care they can receive the most appropriate service; and
- **delivering an e-health agenda** based on personal electronic health records, better use of data, communication and knowledge-led decision support.

In general, the efficiency gains of these reforms have not been separately identified. However, we do have estimates for two reforms: the introduction of activity-based funding and the implementation of personal electronic health records. Looking more closely at these two initiatives illustrates the significance of the efficiency gains for Australia’s health system from our reforms.

The introduction of activity-based funding will achieve efficiency gains because it will drive changes in behaviour, by:

- explicitly linking funds allocated to the services provided;
- making it possible to compare similar/peer hospitals;
- making it easier to determine if benchmarks have been met; and
- helping managers and clinicians to identify inefficient practices, allocate more resources to under-funded activities, control costs, and target unnecessarily high costs.²²⁸

We have estimated that, when fully implemented, activity-based funding of public hospitals and public health services, as recommended in this report, could save an estimated \$570 million to \$1,330 million a year.

227 National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, Background paper prepared for the National Health and Hospitals Reform Commission.

228 National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, Background paper prepared for the National Health and Hospitals Reform Commission.

In terms of the implementation of personal electronic health records, efficiencies are expected to be delivered across all health service settings. Efficiencies would be gained by minimising the need to:

- transcribe medical records;
- wait for paper records to be delivered; and
- re-order tests and diagnostic imaging – the test results and x-rays/scans could be attached to the personal electronic health record.

Adverse events are also expected to be reduced as, with a personal electronic health record, it will be easier to manage medicines (and their interactions) and medical histories (including, for example, allergies).²²⁹ The AIHW has estimated that the introduction of personal electronic health records would save an estimated \$430 million in 2022-23 and \$627 million in 2032-33 (see Table 7.3 above).

Activity-based funding and electronic health records target operational efficiency – that is, they impact on the use of resources in the production and delivery of services. Allocative efficiency is also very important in health care – it is concerned with ensuring the best allocation of resources so that the inputs allocated to the health system yield the best possible outcomes.²³⁰

A number of our reforms are concerned with improving allocative efficiency – including increasing the provision of sub-acute care, reforming aged care provision, implementing advance care planning, and shifting towards prevention and early intervention.

One way of measuring the gains to allocative efficiency is by estimating the number of additional bed days made available from avoiding or reducing the time spent in hospital. Considering the impact of three reforms – increased sub-acute services, improved access to aged care, and advance care planning – there would be significant additional bed days made available in hospitals, estimated at a minimum of 1,064,000 to a maximum of 1,341,000 bed days (see Appendix H). These reforms would translate to ‘freeing up’ about 2,900 hospital beds for other more appropriate use, including meeting relevant National Access Targets. This provides the capacity to provide 160,000 or more episodes of acute care to treat people requiring an overnight hospital stay.

7.5 Conclusions

This chapter has focused on practical issues of implementation, considering an implementation plan for our recommended reforms, and the financial implications of the reforms. We have highlighted the urgency of reform and argued that the implementation of reforms should begin immediately. We have also estimated the recurrent and capital costs of our reforms, while pointing out that, over the medium to long term, our reforms are estimated to reduce projected growth in spending on health and aged care.

Some may query the wisdom of undertaking significant reform of health care, and incurring increased expenditure, at a time when Australia’s economy and government outlays are under pressure from a global financial downturn.

But a healthy population and an efficient and effective health care system are essential to maximising the wellbeing of our nation, and the productivity of our economy and workforce.²³¹ Our recommendations for reform are aimed at achieving an improved distribution of resources to provide more efficient and effective health care over the next five to ten years. Improving the performance of a sector that represents a tenth of our economy – and which is expected to grow to become an eighth of our economy in the next twenty years – is essential to proper economic management.

229 National Health and Hospitals Reform Commission (2009), *The Australian health care system and the potential for efficiency gains: A review of the literature*, Background paper prepared for the National Health and Hospitals Reform Commission.

230 S Duckett (2008), ‘The Australian health care system: reform, repair or replace?’, *Australian Health Review* 32(2): 322-329.

231 Business Council of Australia (2009), Submission 233 to the National Health and Hospitals Reform Commission: Second Round Submissions.

Furthermore, we believe that there is also a cost in not pursuing our recommendations – a cost in terms of the forgone improvements in health status and in equity of health outcomes, and of a less efficient, less responsive health care system, that is also less well prepared for the challenges of the future.

As the reform plan is further refined and put into action, we strongly urge that governments continue to consult with and involve health services, health professionals and the community more widely. There is an enthusiasm and readiness for change that, if constructively harnessed, can ensure Australians continue to enjoy one of the best health systems in the world.

