RECOMMENDATIONS

RECOMMENDATIONS

Taking Responsibility

Individual and collective action to build good health and wellbeing – by people, families, communities, health professionals, employers, health funders and governments

Building good health and wellbeing into our communities and our lives

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

2. Australian governments and the Australian community should acknowledge that the scope of the universal entitlement and service obligation funded by public monies will need to be debated over time to ensure that it is realistic, affordable, fair, and will deliver the best health outcomes, while reflecting the values and priorities of the community. Mechanisms for effectively conducting this dialogue should be developed and should include expert clinical, economic and consumer perspectives.

3. Listening to the views of all Australians about our health system and health reform is essential to the ongoing sustainability and responsiveness of our health system. Accordingly, we recommend regular monitoring and public reporting of community confidence in the health system and the satisfaction of our health workforce.

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

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

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

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

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

9. We recommend the establishment of an independent National Health Promotion and Prevention Agency. This agency would be responsible for national leadership on the Healthy Australia 2020 goals, as well as building the evidence base, capacity and infrastructure that is required so that prevention becomes the platform of healthy communities and is integrated into all aspects of our health care system.

We recommend that the National Health Promotion and Prevention Agency (NHP&PA) would also collate and disseminate information about the efficacy and cost effectiveness of health promotion including primary, secondary and tertiary prevention interventions and relevant population and public health activities.

10. We support strategies that help people take greater personal responsibility for improving their health through policies that 'make healthy choices easy choices'. This includes individual and collective action to improve health by people, families, communities, health professionals, health insurers, employers and governments. Further investigation and development of such strategies should form part of NHP&PA work on the Healthy Australia 2020 Goals, targeting cross portfolio and cross industry action.

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

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

13. To support people's decision making and management of their own health we recommend that, by 2012, every Australian should be able to have a personal electronic health record that will at all times be owned and controlled by that person.

14. We acknowledge the vital role of informal/family carers in supporting and caring for people with chronic conditions, mental disorders, disabilities and frailty. We recommend that carers be supported through educational programs, information, mentoring, timely advice and, subject to the consent of those they care for, suitable engagement in health decisions and communications. We also recommend improved access to respite care arrangements to assist carers sustain their role over time and that the health of carers should also be a priority of primary health care services dealing with people with chronic conditions.

15. We recognise that the health of individuals and the community as a whole is determined by many factors beyond health care, such as a person's social circumstances and the physical environment in which they live; how they live their lives – their behaviours and lifestyles; and their biological and genetic predispositions. We commend the World Health Organisation's call for action by national governments to address the social determinants of health.

Connecting Care

Comprehensive care for people over their lifetime

Creating strong primary health care services for everyone

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

17. We recommend that, in its expanded role, the Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres and Services. We suggest this could be achieved through a range of mechanisms including initial fixed establishment grants on a competitive and targeted basis. By 2015, we should have a comprehensive primary health care system that is underpinned by a national policy and funding framework with services evolving in parallel.

18. We recommend that young families, Aboriginal and Torres Strait Islander people, and people with chronic and complex conditions (including people with a disability or a long-term mental illness) have the option of enrolling with a single primary health care service to strengthen the continuity, coordination and range of multidisciplinary care available to meet their health needs and deliver optimal outcomes. This would be the enrolled family or patient's principal 'health care home'. To support this, we propose that

    - there will be grant funding to support multidisciplinary services and care coordination for that service tied to levels of enrolment of young families and people with chronic and complex conditions;
    - there will be payments to reward good performance in outcomes, including quality and timeliness of care, for the enrolled population; and
    - over the longer term, payments will be developed that bundle the cost of packages of primary health care over a course of care or period of time, supplementing fee-based payments for episodic care.

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

20. We recommend improving the way in which general practitioners, primary health care professionals, and medical and other specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting. These arrangements should promote good communication and the vital role of primary health care professionals in the ongoing management and support of people with chronic and complex conditions in partnership with specialist medical consultants and teams who provide assessment, complex care planning and advice.

21. Service coordination and population health planning priorities should be enhanced at the local level through the establishment of Primary Health Care Organisations, evolving from or replacing the existing Divisions of General Practice. These organisations will need to:

    - have appropriate governance to reflect the diversity of clinicians and services forming comprehensive primary health care;
    - be of an appropriate size to provide efficient and effective coordination (say, approximately 250,000 to 500,000 population depending on health need, geography and natural catchment); and
    - meet required criteria and goals to receive ongoing Commonwealth funding support.

Nurturing a healthy start

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

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

    - most importantly, a partnership with parents, supporting families – and extended families – in enhancing children's health and wellbeing;
    - a life course approach to understanding health needs at different stages of life, beginning with pre-conception, and covering the antenatal and early childhood period up to eight years of age. While the research shows that the first three years of life are particularly important for early development, we also note the importance of the period of the transition to primary school; and

- a child and family-centred approach to shape the provision of health services around the health needs of children and their families. Under a 'progressive universalism' approach, there would be three levels of care: universal, targeted, and intensive care.

23. We recommend beginning the strategy for nurturing a healthy start to life before conception. Universal services would focus on effective health promotion to encourage good nutrition and healthy lifestyles, and on sexual and reproductive health services for young people. Targeted services would include ways to help teenage girls at risk of pregnancy. In the antenatal period, in addition to good universal primary health care, we recommend targeted care for women with special needs or at risk, such as home visits for very young, first-time mothers.

24. We recommend that universal child and family health services provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring (with contacts weighted towards the first three years of life), including:

    - the initial contact would be universally offered as a home visit within the first two weeks following the birth. The schedule would include the core services of monitoring of child health, development and wellbeing; early identification of family risk and need; responding to identified needs; health promotion and disease prevention (for example, support for breastfeeding); and support for parenting;
    - where the universal child and family health services identify a health or developmental issue or support need, the service will provide or identify a pathway for targeted care, such as an enhanced schedule of contacts and referral to allied health and specialist services; and
    - where a child requires more intensive care for a disability or developmental concerns, a care coordinator, associated with a primary health care service, would be available to coordinate the range of services these families often need.

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

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

Ensuring timely access and safe care in hospitals

27. We recommend development and adoption of National Access Targets for timeliness of care. For example:

    - a national access target for people requiring an acute mental health intervention (measured in hours);
    - a national access target for patients requiring urgent primary health care (measured in hours or days);
    - national access targets for people attending emergency departments (measured in minutes to hours);
    - a national access target for patients requiring coronary artery surgery or cancer treatment (measured in weeks/days); and
    - a national access target for patients requiring other planned surgery or procedures (measured in months).

    These National Access Targets should be developed incorporating clinical, economic and community perspectives through vehicles like citizen juries and may evolve into National Access Guarantees subject to ensuring there is no distortion in allocation of health resources.

28. A share of the funding potentially available to health services should be linked to meeting (or improving performance towards) the access targets, payable as a bonus.

29. We recommend there be financial incentives to reward good performance in outcomes and timeliness of care. One element of this should be for timely provision of suitable clinical information (such as discharge information) including details of any follow-up care required.

30. We recommend the use of activity-based funding for both public and private hospitals using casemix classifications (including the cost of capital), which means:

   - this approach should be used for inpatient and outpatient treatment;
   - emergency department services should be funded through a combination of fixed grants (to fund availability) and activity-based funding; and
   - for hospitals with a major emergency department service the costs of maintaining bed availability to admit people promptly should be recognised in the funding arrangements.

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

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

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

34. To better understand people's use of health services and health outcomes across different care settings, we recommend that public and private hospital episode data should be collected nationally and linked to MBS and PBS data using a patient's Medicare card number.

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

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

Restoring people to better health and independent living

37. The visibility of, and access to, sub-acute care services must be increased for people to have the best opportunity to recover from injury or illness and to be restored to independent living. To do this, we recommend:

   - funding must be more directly linked to the delivery and growth of sub-acute services;
   - a priority focus should be the development of activity-based funding models for sub-acute services (including the cost of capital), supported by improvements in national data and definitions for sub-acute services; and
   - the use of activity-based funding complemented by incentive payments related to improving outcomes for patients.

38. We recommend that clear targets to increase provision of sub-acute services be introduced by June 2010. These targets should cover both inpatient and community-based services and should link the demand for sub-acute services to the expected flow of patients from acute services and

other settings. Incentive funding under the National Partnership Payments could be used to drive this expansion in sub-acute services.

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

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

41. We recognise the vital role of equipment, aids and other devices in helping people to improve health functioning and to live as independently as possible in the community. We recommend affordable access to such equipment should be considered under reforms to integrated safety net arrangements.

Increasing choice in aged care

42. We recommend that government subsidies for aged care should be more directly linked to people rather than places. As a better reflection of population need, we recommend the planning ratio transition from the current basis of places per 1000 people aged 70 or over to care recipients per 1000 people aged 85 or over.

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

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

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

46. We recommend development and introduction of streamlined, consistent assessment for eligibility for care across all aged care programs. This should include:
    - transferring the Aged Care Assessment Teams to Commonwealth Government responsibility;
    - developing new assessment tools for assessing people's care needs; and
    - integrating assessment for Home and Community Care Services with more rigorous assessment for higher levels of community and residential care.

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

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

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

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

Notwithstanding this, we note that, given the increase in frailty and complexity of care needs, for many elderly people residential care will remain the best and only viable option for meeting their care needs. The level of care subsidies should be periodically reviewed to ensure they are adequate to meet the care needs of the most frail in residential settings.

In the lead up to freeing up choice of care setting, there should be a phased plan over five years to enable aged care providers to convert existing low care residential places to community places.

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

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

53. The safety, efficiency and effectiveness of care for older people in residential and community settings can be assisted by better and innovative use of technology and communication. We recommend:

    - supporting older people, and their carers, with the person's consent, to activate and access their own person-controlled electronic health record;
    - improved access to e-health, online and telephonic health advice for older people and their carers and home and personal security technology;
    - increased use of electronic clinical records and e-health enablers in aged care homes, including capacity for electronic prescribing by attending medical and other credentialled practitioners, and providing a financial incentive for electronic transfer of clinical data between services and settings (general practitioners, hospital and aged care), subject to patient consent; and
    - the hospital discharge referral incentive scheme must include timely provision of pertinent information on a person's hospital care to the clinical staff of their aged care provider, subject to patient consent.

Caring for people at the end of life

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

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

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

57. We recommend that advance care planning be funded and implemented nationally, commencing with all residential aged care services, and then being extended to other relevant groups in the population. This will require a national approach to education and training of health professionals including greater awareness and education among health professionals of the common law right of people to make decisions on their medical treatment, and their right to decline treatment. We note that, in some states and territories, this is complemented by supporting legislation that relates more specifically to end of life and advance care planning decisions.

Facing Inequities

Recognise and tackle the causes and impacts of health inequities

Closing the health gap for Aboriginal and Torres Strait Islander peoples

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

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

60. We recommend strengthening and expanding organisational capacity and sustainability of Community Controlled Health Services to provide and broker comprehensive primary health care services. We recommend this should occur within OATSIH or a similar group within the Commonwealth Department of Health and Ageing, but should be separate to the purchasing function.

61. Acknowledging that significant additional funding in Aboriginal and Torres Strait Islander health care will be required to close the gap, we recommend that a dedicated, expert commissioning group be established to lead this investment. This could be achieved by the establishment of a National Aboriginal and Torres Strait Islander Health Authority within the Health portfolio to commission and broker services specifically for Aboriginal and Torres Strait Islander people and their families as a mechanism to focus on health outcomes and ensure high quality and timely access to culturally appropriate care.

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

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

64. Good nutrition and a healthy diet are key elements of a healthy start to life. But many Aboriginal and Torres Strait Islander people living in remote areas have limited access to affordable healthy foods. We recommend an integrated package to improve the affordability of fresh food – particularly fruit and vegetables – in these targeted remote communities. This package would include subsidies to bring the price of fresh food in line with large urban and regional centres, investment in nutrition education and community projects, and food and nutrient supplementation for schoolchildren, infants, and pregnant and breastfeeding women. The strategy would be developed in consultation with these Aboriginal and Torres Strait Islander communities, building on some of the successful work already underway. There would be an evaluation to assess the benefits of extending the program to other communities, focusing on the changes to eating habits and improvements to health.

Delivering better health outcomes for remote and rural communities

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

    - funding equivalent to national average medical benefits and primary health care service funding, appropriately adjusted for remoteness and health status, be made available for local service provision where populations are otherwise under-served; and

- expansion of the multi-purpose service model to towns with catchment populations of approximately 12,000.

66. Care for people in remote and rural locations necessarily involves bringing care to the person or the person to the care. To achieve this, we recommend:

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

    Further, we recommend that funding mechanisms be developed to support all these elements.

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

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

69. We recommend building health service, clinical and workforce capability through a remote and rural health research program.

70. We recommend that the Clinical Education and Training Agency take the lead in developing:

    - an integrated package of strategies to improve the distribution of the health workforce. This package could include strategies such as providing university fee relief, periodic study leave, locum support, expansion of medical bonded scholarships and extension of the model to all health professions; and
    - preferential access for remote and rural practitioners to training provided by specialty colleges recognising related prior learning and clinical experience and/or work opportunities for practitioners returning to the city, and support for those who plan to return again to remote or rural practice once specialty attained.

Supporting people living with mental illness

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

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

73. We recommend that every acute mental health service have a rapid-response outreach team for those individuals experiencing psychosis, and subsequently have the acute service capacity to provide appropriate treatment.

74. We recommend that every hospital-based mental health service should be linked with a multi-disciplinary community-based sub-acute service that supports 'stepped' prevention and recovery care.

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

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

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

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

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

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

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

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

82. We acknowledge the important role of carers in supporting people living with mental disorders. We recommend that there must be more effective mechanisms for consumer and carer participation and feedback to shape programs and service delivery.

Improving oral health and access to dental care

83. We recommend that all Australians should have universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay. This should occur through the establishment of the 'Denticare Australia' scheme. Under the 'Denticare Australia' scheme, people will be able to select between private or public dental health plans. 'Denticare Australia' would meet the costs in both cases. The additional costs of Denticare could be funded by an increase in the Medicare Levy of 0.75 per cent of taxable income.

84. We recommend the introduction of a one-year internship scheme prior to full registration, so that clinical preparation of oral health practitioners (dentists, dental therapists and dental hygienists) operates under a similar model to medical practitioners. We recognise that this will require an investment in training and capital infrastructure.

85. We recommend the national expansion of the pre-school and school dental programs.

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

Driving Quality Performance

Leadership and systems to achieve best use of people, resources and evolving knowledge

Strengthening the governance of health and health care

87. To give effect to a national health system, we recommend that First Ministers 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 the Australian population.

88. The Healthy Australia Accord would incorporate the following substantial structural reforms to the governance of the health system:

88.1 The Commonwealth Government would assume full responsibility for the policy and public funding of primary health care services. This includes all existing community health, public dental services, family and child health services, and alcohol and drug treatment services that are currently funded by state, territory and local governments.

88.2 The Commonwealth and state and territory governments would move to new transparent and more equitable funding arrangements for public hospitals and public health care services as follows:

- The Commonwealth Government would meet 100 per cent of the efficient costs of public hospital outpatient services using an agreed casemix classification and an agreed, capped activity-based budget;
- The Commonwealth Government would pay 40 per cent of the efficient cost of care for every episode of acute care and sub-acute care for public patients admitted to a hospital or public health care facility for care, and for every attendance at a public hospital emergency department; and
- As the Commonwealth Government builds capacity and experience in purchasing these public hospital and public health care services, this approach provides the opportunity for its share to be incrementally increased over time to 100 per cent of the efficient cost for these services. In combination with the recommended full funding responsibility by the Commonwealth Government for primary health care and aged care, these changes would mean the Commonwealth Government would have close to total responsibility for government funding of all public health care services across the care continuum – both inside and outside hospitals. This would give the Commonwealth Government a comprehensive understanding of health care delivery across all services and a powerful incentive – as well as the capacity – to reshape funding and influence service delivery so that the balance of care for patients is effective and efficient.

88.3 The Commonwealth Government would pay 100 per cent of the efficient cost of delivering clinical education and training for health professionals across all health service settings, to agreed target levels for each state and territory.

88.4 The Commonwealth Government would assume full responsibility for the purchasing of all health services for Aboriginal and Torres Strait Islander people through the establishment of a National Aboriginal and Torres Strait Islander Health Authority. This would include services that are provided through mainstream and Community Controlled Health Services, including services that are currently funded by state, territory and local governments.

88.5 The Commonwealth Government would assume full responsibility for providing universal access to dental care (preventive, restorative and dentures). This would occur through the establishment of the 'Denticare Australia' scheme.

88.6 The Commonwealth Government would assume full responsibility for public funding of aged care. This would include the Home and Community Care Program for older people and aged care assessment.

88.7 The assumption of greater financial responsibility by the Commonwealth Government for the above health services would be met through commensurate reductions in grants to states, territories and local governments and/or through changes to funding agreements between governments.

88.8 These changes to roles and responsibilities allow for the continued involvement of states, territories and local governments in providing health services.

88.9 The Commonwealth, state and territory governments would agree to establish national approaches to health workforce planning and education, professional registration, patient safety and quality (including service accreditation), e-health, performance reporting (including the provision of publicly available data on the performance of all aspects of the health system), prevention and health promotion, private hospital regulation, and health intervention and technology assessment.

89. We believe that there is a real need to further improve the responsiveness and efficiency of the health system and capacity for innovation. We agree that greater consumer choice and provider competition and better use of public and private health resources could offer the potential to achieve this through the development of a uniquely Australian governance model for health care that builds on and expands Medicare. This new model is based on the establishment of health and hospital plans, and draws upon features of social health insurance as well as encompassing ideas of consumer choice, provider competition and strategic purchasing. We have given this new governance model the working title, 'Medicare Select'.

90. We recommend that the Commonwealth Government commits to explore the design, benefits, risks and feasibility around the potential implementation of health and hospital plans to the governance of the Australian health system. This would include examination of the following issues:

90.1 The basis for determination of the universal service entitlement to be provided by health and hospital plans (including the relationship between the Commonwealth Government and health and hospital plans with regard to growth in the scope, volume, and costs of core services, the process for varying the level of public funding provided to the health and hospital plans for purchasing of core services; and the nature of any supplementary benefits that might be offered by plans);

90.2 The scope, magnitude, feasibility and timing of financial transfers between state, territory and local governments and the Commonwealth Government in order to achieve a single national pool of public funding to be used as the basis for funding health and hospital plans;

90.3 The basis for raising financing for health and hospital plans (including the extent to which transparency should be promoted through use of a dedicated levy or through publicly identifying the share of consolidated revenue that makes up the universal service entitlement);

90.4 The potential impact on the use of public and private health services including existing state and territory government funded public hospitals and other health services (incorporating consideration of whether regulatory frameworks for health and hospital plans should influence how plans purchase from public and private health services including whether there should be a requirement to purchase at a default level from all hospitals and primary health care services);

90.5 The approach to ensuring an appropriate level of investment in capital infrastructure in public and private health services (including different approaches to the financing of capital across public and private health services and the treatment of capital in areas of market failure);

90.6 The relationship between the health and hospital plans and the continued operation of the Medicare and Pharmaceutical Benefits Schemes (including whether there should continue to be national evaluation, payment and pricing arrangements and identifying what flexibility in purchasing could be delegated to health and hospital plans concerning the coverage, volume, price, and other parameters in their purchasing of medical and pharmaceutical services in hospitals and the community);

90.7 The potential role of private health insurance alongside health and hospital plans (including defining how private health insurance would complement health and hospital plans, the potential impact on membership, premiums, insurance products and the viability of existing private health insurance; and any changes to the Commonwealth Government's regulatory, policy or financial support for private health insurance);

90.8 The potential roles of state, territory and local governments under health and hospital plans (including issues related to the handling of functions such as operation of health services, employment of staff, industrial relations and the implications for transmission of business and any required assumption of legislative responsibility by the Commonwealth Government related to these changed functions, together with the operation by state and territory governments of health and hospital plans);

90.9 The range of responsibilities and functions to be retained or assumed by Australian governments (and not delegated to health and hospital plans) in order to ensure national consistency or to protect 'public good' functions (including, as potential examples, functions such as health workforce education and training, research, population and public health and bio security);

90.10 The approach to ensuring equitable access to health services in areas of market failure including in remote and rural areas of Australia (including the relevant roles of health and hospital plans in regard to the development and capacity building of a balanced supply and distribution of health services, and the approach by plans to regional and local consultation and engagement on population needs);

90.11 The necessary regulatory framework to support the establishment and operation of health and hospital plans (including issues relating to entry and exit of plans, minimum standards for the establishment of plans, any requirements relating to whether plans are able to also provide health services, and the potential separation of health and hospital plans and existing private health insurance products);

90.12 The development of appropriate risk-adjustment mechanisms to protect public funding and consumers (including potential mechanisms such as the use of risk-adjusted payments by the Commonwealth Government to health and hospital plans, reinsurance arrangements and risk-sharing arrangements related to scope, volume and cost of services covered under health and hospital plans);

90.13 The necessary regulatory framework to protect consumers (including potential requirements around guaranteed access, portability, co-payments, information provision on any choices or restrictions relating to eligible services and health professionals/health services covered under individual health and hospital plans, and measures to regulate anti-competitive behaviours and complaints mechanisms).

Raising and spending money for health services

91. Health and aged care spending is forecast to rise to 12.4 per cent of gross domestic product in 2032–33. We believe that:

- major reforms are needed to improve the outcomes from this spending and national productivity and to contain the upward pressure on health care costs; and
- improved health outcomes are vital in promoting a healthy economy through greater productivity and higher labour force participation; and

- evidence-based investment in strengthened primary health care services and prevention and health promotion to keep people healthy is required to help to contain future growth in spending.

92. We want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade.

93. We recommend a systematic mechanism to formulating health care priorities that incorporates clinical, economic and community perspectives through vehicles like citizen juries.

94. We recommend a review of the scope and structure of safety net arrangements to cover a broader range of health costs. We want an integrated approach that is simpler and more family-centred to protect families and individuals from unaffordably high out-of-pocket costs of health care.

95. We recommend that incentives for improved outcomes and efficiency should be strengthened in health care funding arrangements.

    This will involve a mix of:

    - activity-based funding (e.g. fee for service or casemix budgets). This should be the principal mode of funding for hospitals;
    - payments for care of people over a course of care or period of time. There should be a greater emphasis on this mode of funding for primary health care; and
    - payments to reward good performance in outcomes and timeliness of care. There should be a greater emphasis on this mode of funding across all settings.

    We further recommend that these payments should take account of the cost of capital and cover the full range of health care activities including clinical education.

96. We believe that funding arrangements may need to be adjusted to take account of different costs and delivery models in different locations and to encourage service provision in under-served locations and populations.

97. Additional capital investment will be required on a transitional basis to facilitate our recommendations. In particular, we recommend that priority areas for new capital investment should include:

    - the establishment of Comprehensive Primary Health Care Centres and Services;
    - an expansion of sub-acute services including both inpatient and community-based services;
    - investments to support expansion of clinical education across clinical service settings; and
    - targeted investments in public hospitals to support reshaping of roles and functions, clinical process redesign and a reorientation towards community-based care; and
    - capital can be raised through both government and private financing options.

    The ongoing cost of capital should be factored into all service payments.

Working for us: a sustainable health workforce for the future

98. We recommend supporting our health workforce by:

    - promoting a culture of mutual respect and patient focus of all health professions through shared values, management structures, compensation arrangements, shared educational experiences, and clinical governance processes that support team approaches to care;
    - supporting effective communication across all parts of the health system;

- investing in management and leadership skills development and maintenance for managers and clinicians at all levels of the system;
- promoting quality and a continuous improvement culture by providing opportunities and encouraging roles in teaching, research, quality improvement processes, and clinical governance for all health professionals across service settings;
- providing timely relevant data on comparative clinical performance and latest practice knowledge to support best practice and continuous quality improvement;
- improving clinical engagement through mechanisms to formally and informally involve all health professionals in guiding the management and future directions of health reform including establishing Clinical Senates at national, regional and local levels, subject-specific taskforces, and conducting health workforce opinion surveys; and
- recognising and supporting the health needs of health workers including setting the benchmark for best practice in workplace health programs.

99. To improve access to care and reflect current and evolving clinical practice, we recommend that:

- Medicare rebates should apply to relevant diagnostic services and specialist medical services ordered or referred by nurse practitioners and other health professionals having regard to defined scopes of practice determined by recognised health professional certification bodies;
- Pharmaceutical Benefits Scheme subsidies (or, where more appropriate, support for access to subsidised pharmaceuticals under section 100 of the National Health Act 1953) should apply to pharmaceuticals prescribed from approved formularies by nurse practitioners and other registered health professionals according to defined scopes of practice;
- where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialled for defined scopes of practice; and
- the Medicare Benefits Schedule should apply to specified activities performed by a nurse practitioner, midwife or other competent health professional, credentialled for defined scopes of practice, and where collaborative team models of care with a general practitioner, specialist or obstetrician are demonstrated.

100. We recommend a new education framework for the education and training of health professionals:

- moving towards a flexible, multi-disciplinary approach to the education and training of all health professionals;
- incorporating an agreed competency-based framework as part of broad teaching and learning curricula for all health professionals;
- establishing a dedicated funding stream for clinical placements for undergraduate and postgraduate students; and
- ensuring clinical training infrastructure across all settings (public and private, hospitals, primary health care and other community settings).

101. To ensure better collaboration, communication and planning between the health services and health education and training sectors, we recommend the establishment of a National Clinical Education and Training Agency:

- to advise on the education and training requirements for each region;
- to assist with planning clinical education infrastructure across all service settings, including rural and remote areas;
- to form partnerships with local universities, vocational education and training organisations, and professional colleges to acquire clinical education placements from health service providers, including a framework for activity-based payments for undergraduates' clinical education and postgraduate training;

- to promote innovation in education and training of the health workforce;
- as a facilitator for the provision of modular competency-based programs to up-skill health professionals (medical, nursing, allied health and Aboriginal health workers) in regional, rural and remote Australia; and
- to report every three years on the appropriateness of accreditation standards in each profession in terms of innovation around meeting the emerging health care needs of the community.

Further, we recommend that the governance, management and operations of the Agency should include a balance of clinical and educational expertise, and public and private health services representation in combination with Commonwealth and state health agencies.

While the Agency has an overarching leadership function, it should support implementation and innovation at the local level.

102. We support national registration to benefit the delivery of health care across Australia.

103. We recommend implementing a comprehensive national strategy to recruit, retain and train Aboriginal and Torres Strait Islander health professionals at the undergraduate and postgraduate level including:

- setting targets for all education providers, with reward payments for achieving health professional graduations;
- funding better support for Aboriginal and Torres Strait Islander health students commencing in secondary education; and
- strengthening accrediting organisations' criteria around cultural safety.

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

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

Fostering continuous learning in our health system

105. To promote research and uptake of research findings in clinical practice, we recommend that clinical and health services research be given higher priority. In particular, we recommend that the Commonwealth increase the availability of part-time clinical research fellowships across all health sectors to ensure protected time for research to contribute to this endeavour.

106. We recommend greater investment in public health, health policy, health services and health system research including ongoing evaluation of health reforms.

107. We further recommend that infrastructure funding (indirect costs) follow direct grants whether in universities, independent research institutes, or health service settings.

108. We believe that the National Health and Medical Research Council should consult widely with consumers, clinicians and health professionals to set priorities for collaborative research centres and supportive grants which:

- integrate multidisciplinary research across care settings in a 'hub and spoke' model; and
- have designated resources to regularly disseminate research outcomes to health services.

109. To enhance the spread of innovation across public and private health services, we recommend that:

- the National Institute of Clinical Studies broaden its remit to include a 'clearinghouse' function to collate and disseminate innovation in the delivery of safe and high quality health care;
- health services and health professionals share best practice lessons by participating in forums such as breakthrough collaboratives, clinical forums, health roundtables, and the like; and
- a national health care quality innovation awards program is established.

110. To help embed a culture of continuous improvement, we recommend that a standard national curriculum for safety and quality is built into education and training programs as a requirement of course accreditation for all health professionals.

111. The Australian Commission for Safety and Quality in Health Care should be established as a permanent, independent national body. With a mission to measurably improve the safety and quality of health care, the ACS&QHC would be an authoritative knowledge-based organisation responsible for:

Promoting a culture of safety and quality across the system:

- disseminating and promoting innovation, evidence and quality improvement tools;
- recommending national data sets with a focus on the measurement of safety and quality;
- identifying and recommending priorities for research and action;
- advocating for safety and quality; and
- providing advice to governments, bodies (e.g. NHMRC, TGA), clinicians and managers on 'best practice ' to drive quality improvement.

Analysing and reporting on safety and quality across all health settings:

- reporting and public commentary on policies, progress and trends in relation to safety and quality;
- developing and conducting national patient experience surveys; and
- reporting on patient reported outcome measures.

Monitoring and assisting in regulation for safety and quality:

- recommending nationally agreed standards for safety and quality, including collection and analysis of data on compliance against these standards. The extent of such regulatory responsibilities requires further consideration of other compliance activities such as accreditation and registration processes.

112. To drive improvement and innovation across all areas of health care, we recommend that a nationally consistent approach is essential to the collection and comparative reporting of indicators which monitor the safety and quality of care delivery across all sectors. This process should incorporate:

- local systems of supportive feedback, including to clinicians, teams and organisations in primary health services and private and public hospitals; and
- incentive payments that reward safe and timely access, continuity of care (effective planning and communication between providers) and the quantum of improvement (compared to an evidence base, best practice target or measured outcome) to complement activity-based funding of all health services.

113. We also recommend that a national approach is taken to the synthesis and subsequent dissemination of clinical evidence/research, which can be accessed via an electronic portal and adapted locally to expedite the use of evidence, knowledge and guidelines in clinical practice.

114. As part of accreditation requirements, we believe that all hospitals, residential aged care services and Comprehensive Primary Health Care Centres and Services should be required to publicly report on progress with quality improvement and research.

Implementing a national e-health system

115. We recommend that, by 2012, every Australian should be able to:

- have a personal electronic health record that will at all times be owned and controlled by that person;
- approve designated health care providers and carers to have authorised access to some or all of their personal electronic health record; and
- choose their personal electronic health record provider.

116. We recommend that the Commonwealth Government legislate to ensure the privacy of a person's electronic health data, while enabling secure access to the data by the person's authorised health providers.

117. We recommend that the Commonwealth Government introduce:

- unique personal identifiers for health care by 1 July 2010; unique health professional identifiers (HPI-I), beginning with all nationally registered health professionals, by 1 July 2010;
- a system for verifying the authenticity of patients and professionals for this purpose – a national authentication service and directory for health (NASH) – by 1 July 2010; and
- unique health professional organisation (facility and health service) identifiers (HPI-O) by 1 July 2010.

118. We recommend that the Commonwealth Government develop and implement an appropriate national social marketing strategy to inform consumers and health professionals about the significant benefits and safeguards of the proposed e-health approach.

119. Ensuring access to a national broadband network (or alternative technology, such as satellite) for all Australians, particularly for those living in isolated communities, will be critical to the uptake of person-controlled electronic health records as well as to realise potential access to electronic health information and medical advice.

120. We recommend that the Commonwealth Government mandate that the payment of public and private benefits for all health and aged care services depend upon the ability to accept and provide data to patients, their authorised carers, and their authorised health providers, in a format that can be integrated into a personal electronic health record, such that:

- hospitals must be able to accept and send key data, such as referral and discharge information ('clinical information transfer'), by 1 July 2012;
- pathology providers and diagnostic imaging providers must be able to provide key data, such as reports of investigations and supplementary information, by 1 July 2012;
- other health service providers – including general practitioners, medical and non-medical specialists, pharmacists and other health and aged care providers – must be able to transmit key data, such as referral and discharge information ('clinical information transfer'), prescribed and dispensed medications and synopses of diagnosis and treatment, by 1 January 2013; and
- all health care providers must be able to accept and send data from other health care providers by 2013.

121. We recommend that the Commonwealth Government takes responsibility for, and accelerates the development of a national policy and open technical standards framework for e-health, and that they secure national agreement to this framework for e-health by 2011-12. These standards should include key requirements such as interoperability, compliance and security. The standards should be developed with the participation and commitment of state governments, the IT vendor industry, health professionals, and consumers, and should guide the long-term convergence of local systems into an integrated but evolving national health information system.

122. We recommend that significant funding and resources be made available to extend e-health teaching, training, change management and support to health care practitioners and managers. In addition, initiatives to establish and encourage increased enrolment in nationally recognised tertiary qualifications in health informatics will be critical to successful implementation of the national e-health work program. The commitment to, and adoption of, standards-compliant e-health solutions by health care organisations and providers is key to the emergence of a national health information system and the success of person-controlled electronic health records.

123. With respect to the broader e-health agenda in Australia, we concur with and endorse the directions of the National E-Health Strategy Summary (December 2008), and would add that:

- there is a critical need to strengthen the leadership, governance and level of resources committed by governments to giving effect to the planned National E-Health Action Plan;
- this Action Plan must include provision of support to public health organisations and incentives to private providers to augment uptake and successful implementation of compliant e-health systems. It should not require government involvement with designing, buying or operating IT systems;
- in accordance with the outcome of the 2020 Summit and our direction to encourage greater patient involvement in their own health care, that governments collaborate to resource a national health knowledge web portal (comprising e-tools for self-help) for the public as well as for providers. The National Health Call Centre Network (healthdirect) may provide the logical platform for delivery of this initiative; and
- electronic prescribing and medication management capability should be prioritised and coordinated nationally, perhaps by development of existing applications (such as PBS online), to reduce medication incidents and facilitate consumer amenity.