Australian Health Care
Reform Alliance

Position Papers

July 2007

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Australian Health Care Reform Alliance

SUMMARY OF POSITIONS

The vision of the Australian Health Care Reform Alliance (AHCRA)

AHCRA's vision is a health system that assists individuals to be healthy and delivers compassionate and quality health care to all.

Recommendations for health reform

- The establishment of primary health care centres where health professionals deliver care in a multidisciplinary team based environment.
- Further pooling of federal, state and territory health funding to facilitate the delivery of better integrated health care services and minimise duplication, potentially saving more than $2 billion annually.
- The allocation of substantial additional funded places in the higher and vocational education sectors, and broader strategies for entry, retention, and re-entry to the health workforce.
- Additional funding to address the appalling health outcomes of Indigenous Australians.
- Ensuring our health system is equitable – and addresses the health needs of all Australians, including for example, people living in rural and remote areas, as well as those with special needs, and those affected by poverty.
- Health care system reform built on a partnership between the Australia community and consumers – with health policy grounded in and measured against community values.

Who we are

The Australian Health Care Reform Alliance (AHCRA) is an independent alliance of 43 consumer, clinical, health professional, health care provider, and academic organisations that have agreed on a program of reform for the Australian health care sector that will improve access, equity, efficiency and effectiveness.

What we see as the current problems with the Australian health care system

The quality and availability of health care in Australia is deteriorating – a situation which is totally unacceptable in a country as wealthy and prosperous as Australia.

Our health workforce is overstretched, with severe skills shortages in many health professions. Australians are not always able to access necessary health care services when and where they need them. Jurisdictional inefficiencies plague our system of health

funding, preventing accountability and transparency. There is an over emphasis on the provision of hospital based acute care services. Multiple funding streams means services are duplicated - and billions of dollars are wasted each year. Initiatives for health promotion and illness prevention are neglected and poorly supported, turning what should be a “health” system, where health is optimised and promoted, into an “illness” system. The views of consumers are overlooked. Out of pocket expenses are increasing. Aboriginal and Torres Strait Islander health is a national disgrace. And rural and remote Australians suffer poorer health outcomes than their urban counterparts.

It is the view of the members of AHCRA that reform is now essential

AHCRA believes the following principles must underpin our Australian health system:

- Universal access – as a right, in a timely fashion, to an appropriate service, available equally to all on the basis of health needs, not ability to pay;
- Equity of health outcomes – irrespective of socio-economic status, race, cultural background, disability, mental illness, age, gender or location;
- Health care services must be focussed on the needs of patients and their carers and to help Australians avoid illness;
- Health promotion – preventing disease and maintaining health must be appropriately emphasised and balanced with our duty of care to those already unwell;
- Personal and corporate tax contributions should fund our health care. This is the way we wish to provide health insurance to each other;
- A fair balance of public and private resources is needed to ensure equitable health outcomes for all Australians;
- The health outcomes of Aboriginal and Torres Strait Islander Australians must be improved so that they match those of other Australians;
- Health services must be appropriate, safe and of high quality;
- The community – especially consumers and carers, must play an integral part in the development, planning and implementation of our health services;

The health workforce must be valued and appropriately supported.

AHCRA’s vision for health reform

Increasing inequity in the delivery of health care is undermining Australia as a nation and must be reversed. An equitable health care system must ensure that those with special needs, such as people with disability or those whose access to healthcare is restricted by cultural, linguistic or geographic factors, can enjoy health outcomes equivalent to that of the general community. It should address, as a matter of priority, the appalling health status of Australia’s Aboriginal and Torres Strait Islander people.

Achieving an equitable health system requires the development of a national process to measure the success of health systems performance, and this is a current priority for AHCRA. Access to safe and affordable health care requires a safe and sufficient workforce. There are insufficient numbers of nurses, doctors and allied health professionals. The average age of nurses in Australia is 47 years old, and many will retire in 10-15 years. We need to double the current annual intake of nurses in order to meet the nursing care demands of our ageing population – more than 2,000 eligible applicants are currently turned away from nursing education courses each year.

Without increased investment in the education of health professionals, Australians will continue to struggle to gain access, in a timely manner, to services that maintain and support health and offer quality health care to those in need.

A whole-of-government approach is required to address the immediate demands on the health workforce. This requires the allocation of substantial additional funded places in the higher (both undergraduate and postgraduate) and vocational education sectors; sufficient funding for satisfactory clinical placements; improved strategies for entry, retention and re-entry to the health workforce; and an increased emphasis on teaching and research, so crucial to quality care.

As well as increased numbers we also need to restructure the health workforce and its inter-relationships.

Achieving sustainability in the health workforce will be assisted by changes in the way health care is funded and administered. Currently there is a poor distribution of health professionals. Incentives to practice in 'hard to recruit' areas need to be extended to all professions. There is a need for additional scholarships to enable students from rural backgrounds to study medicine, nursing, pharmacy and allied health courses.

Increasing our workforce should not include the recruitment of health professionals from overseas, as many come from countries whose health systems and outcomes are poorer than ours. AHCRA supports the development of a national workforce policy for Australia that aims to train enough Australians to care for our health needs, as well as developing extra capacity over time to support other countries in our region.

This policy should be administered by a single agency, such as a National Health Reform Council, to ensure coordination between health workforce requirements and the funding of education of the health workforce.

Integration – one system working together

Better integration of workforce and education planning is urgently required, as is further integration of all health services, in order to improve the quality of services, and minimise duplication and cost shifting. There is increasing recognition of the need to find solutions to jurisdictional inefficiencies, but we need action, not further rhetoric.

A National Health Reform Council

The formation of a National Health Reform Council (NHRC), answerable directly to the Council of Australian Governments (COAG), would ensure a "whole of government" approach, and facilitate a holistic approach to health in which, for example, adequate housing would be considered in the context of healthy communities.

The NHRC would devise and implement policy, in consultation with clinicians and consumers. It could effectively address the integration of current and future programs, both locally and across the nation, across all health services, from community to hospital to primary care, and in doing so improve quality, cost-effectiveness, and achieve better health outcomes.

Primary health care – a shift in focus

AHCRA believes health care systems should be designed to maximise health promotion and preventive strategies, to allow early diagnosis and treatment to minimise the development of chronic disease, and provide support to allow individuals to maximise their own health.

In order to be effective, primary health care must be readily available to all people in Australia. This includes Aboriginal and Torres Strait Islander people, people living in rural and remote Australia, people with disability, people from culturally and linguistically diverse backgrounds, those on low incomes, or with mental health problems, the homeless, refugees, and people seeking asylum. To achieve this necessary focus on "wellness" and to improve health outcomes, Australia needs a National Primary Health Care Policy, developed in consultation with both consumers and health professionals, with oversight by the National Health Reform Council. Addressing the social determinants of health – issues like housing, education and transport – should be addressed in the National Primary Health Care Policy.

AHCRA believes the management of ever more common chronic illnesses should be undertaken by multidisciplinary teams who can offer health promotion and preventive health care. Around 80% of illnesses among the elderly are potentially preventable through lifestyle interventions. But opportunities to prevent these illnesses are not being supported by our current system. Effective primary health care would reduce hospital utilisation through early intervention. For example, providing comprehensive health education to a person aged 30 who smokes and is overweight via a multidisciplinary approach based on smoking cessation, healthy nutrition, and physical activity, is a sound primary health care approach. Why wait until a patient is grossly obese, has diabetes and depression, and is unable to undertake even minimal levels of physical activity before we act?

The delivery of primary health care services through multidisciplinary teams will require trialing and evaluation of new multidisciplinary models of care and new models of health care funding. Many such models do exist, and those that are shown to be most effective should be expanded throughout the country. Achieving these changes will require political will, as well as a funding system that rewards primary health care teams when their patients are well.

Community engagement

The involvement of consumers in health care decision-making is crucial in developing sound public policy, and is vital for validation of the principles that underpin our national health system. Our increasingly fragmented health system, with multiple funding sources, is subject to ever increasing pressures and rising consumer demand and expectations. Increasingly, clinicians and health managers are being forced to make decisions about the allocation of scarce resources. Who should receive the next hip replacement? How many premature babies should one unit support? Decisions like these are being made every day, and AHCRA believes Australian citizens (all of whom will require health interventions at some point) need to be involved in such decisions. A national dialogue with citizens and consumers could create a common set of values, principles and priorities, and provide the first national vision and framework for health care to inform all

governments in Australia. Such a process is not unique, and has provided sound guidance for public policy decisions in Canada, the UK, Sweden, France and New Zealand. Involving consumers in a collaborative process of health reform allows consumers to engage with the difficult choices involved in health care decision-making in a cost-constrained environment; build consensus and community trust; and allow consumers to convey important information to policymakers about their values and principles. AHCRA is currently involved in developing a proposal that would see such a process take place. This would inevitably lead our health system towards a more efficient and more equitable system.

In summary, AHCRA recommends:

- the establishment of primary health care centres where health professionals deliver care in a multidisciplinary team based environment;
- further pooling of federal, state and territory health funding to facilitate the delivery of better integrated health care services and minimise duplication, potentially saving more than $2 billion annually;
- the allocation of substantial additional funded places in the higher and vocational education sectors, and broader strategies for entry, retention, and re-entry to the health workforce;
- additional funding to address the appalling health outcomes of Indigenous Australians;
- that we ensure our health system is equitable – and addresses the health needs of all Australians, including for example, those with special needs, those affected by poverty, or those who are geographically isolated; and
- that health care system reform be built on a partnership between the Australia community and consumers – with health policy grounded in and measured against community values.

The reforms proposed by AHCRA would see the Australian population receive health care based on the best available evidence, delivered by the most appropriate skilled professional, with greater economic efficiencies and better health outcomes.

With billions of taxpayer's dollars currently being wasted, and sections of the population dying prematurely from avoidable disease, not undertaking reform is not an option.

The time for courageous policy making is now. There is a substantial national budget surplus. The community wants health to be a national priority. We have the means, and the opportunity, to bring about significant change. All that is needed is governments who are willing to accept responsibility for bold decisions, and the courage to act.

AHCRA www.healthreform.org.au is keen to assist with this critical national challenge.

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Australian Health Care Reform Alliance

IMPROVING INDIGENOUS HEALTH

1. Introduction

The Aboriginal and Torres Strait Islander population of Australia is estimated at 458,500, or 2.4% of the total population[1]. Seventy percent of Aboriginal and Torres Strait Islander people live outside major capital cities, and around one quarter live in discrete Indigenous communities.

According to the Australian Institute of Health and Welfare, "the available evidence suggests that Indigenous people continue to suffer a greater burden of ill health than the rest of the population[2]." Indigenous life expectancy is 17 years less than for the total population. Indigenous babies die at the same rate as in some of the most impoverished countries in the world.

In *Healthy Horizons*, the Australian Government gives highest priority to the health of Indigenous Australians and endorses the goal to "improve highest priorities first".

Health care reform in the Indigenous context is an opportunity to address a broad range of health determinants, to be proactive about health promotion and early intervention, to increased services and access to services that are culturally safe, and thereby to improve health outcomes and close the gap in life expectancy.

2. Broadening the view

> *Health is determined by environmental, social, economic and biological factors, and health care alone is not the answer to any community's health problems. Indigenous people's health in particular is affected by the history of colonisation, and the ensuing economic and educational disadvantage, cultural dislocation, social exclusion, remoteness and other factors specific to their situations.*
>
> *Both Indigenous and other commentators refer to a failure of public policy to address the broader social, economic and cultural determinants of poor health outcomes for Indigenous Australians. The deep and widespread problems of poverty, breakdown in*

[1] AIHW http://www.aihw.gov.au/indigenous/ (accessed 7 June 2007)
[2] ibid

family relationships and family violence, youth alienation, and abuse of alcohol and drugs have complex causation.[3]

Much of the good health enjoyed by the general Australian population arises from our very high standard of living, the availability of fresh food and water, hygienic living conditions, an informed awareness of what good health is, a high level of professional and public understanding of communicable disease and how to prevent it, and access to a wide range of qualified and accredited health professionals. This is not the case in many Indigenous communities where many preventable diseases, such as rheumatic fever, renal failure, cardiovascular disease, scabies and severe gum disease, are at epidemic proportions, and where low standards of hygiene, risk-filled lifestyles, poor health knowledge and limited access to services exacerbate the problem.

A reformed health system will be one that takes account of those particular conditions and characteristics which promote health and those which cause ill health and social isolation. An expanded and more accurate recognition of the way health is established, promoted, treated, managed, and restored will allow 'health' funding to be more substantially directed towards addressing the social determinants of ill health and promoting those circumstances which lead to good health, and to be more equitably distributed between the various health professions.

3. Addressing foundational health determinants

The key determinants of Indigenous poor health need to be identified and addressed. There are many who believe poor Indigenous health has its origins in poverty, poor nutrition, overcrowded housing, inner city homelessness, lower education levels, unemployment, social disempowerment, and living conditions conducive to the spread of disease. If this is so, the foundations of the solution will be found in the reliable supply of fresh water and management of waste water, affordable fresh food, access to education (both primary and secondary), income-earning opportunities, as well as health education through various means, including the arts, and health education to produce a higher level of self-management capability. The need for improved oral health services for remote Indigenous communities and access to these cannot be overstated. Less tangible factors including cultures, languages, rituals and customs, if recognised and celebrated, could also have a positive impact on health status for many.

Easier access to culturally appropriate primary health care and child and youth health programs is of pressing importance, but major investment in health services will not achieve the desired outcomes if the basic, underlying determinants of good health are missing. It has been pleasing to see the Government's recent food safety and quality initiatives for remote communities, including the *Outback Stores* and the *Remote Indigenous Stores and Takeaways* projects, a part of the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010. There are also new 'illicit drugs and alcohol' programs.

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[3] Dwyer J, Silburn K and Wilson G (2004). *National Strategies for Improving Indigenous Health and Health Care*. Office for Aboriginal and Torres Strait Islander Health, Australian Department of Health and Aging, Canberra.

4. Consultation

Governments need to be rigorous but not intrusive in their endeavours to determine the underlying causes of the life expectancy gap between Indigenous and non-Indigenous Australians and of the violence, substance abuse, welfare dependency, and high rate of preventable diseases.

To develop effective programs that will be readily accepted by Aboriginal and Torres Strait Islander people, governments need to collaborate with peak Indigenous and non-Indigenous health bodies to look at ways of addressing the issues underlying poorer Indigenous health. The goal should be to fully engage with Aboriginal and Torres Strait Islander people at the local level in a way that will empower them to look after their own health[4].

Indigenous communities on Lands have serious infrastructure and cultural challenges. AHCRA supports greater consultation with Indigenous communities and recognises that, while genuine consultation with people in more remote areas, and inter-culturally, is harder and more expensive for all involved, it must continue.

Whatever models of care are adopted, safety, quality and cultural appropriateness remain paramount.

5. Education and training of Indigenous health professionals

It is internationally recognised that the most effective and ethical way to improve access, health status and life expectancy for Indigenous people is by and through Indigenous people[5]. Currently a very low proportion of the Indigenous population works in health. At present, there are about 90 Indigenous doctors in Australia. As a nation we must do more to equip and attract Aboriginal and Torres Strait Islander people to the health professions and to retain them in practice.

The Government needs to support the community-controlled health sector as a key part of the system. All health professionals should receive culturally appropriate education and training with a focus on chronic disease care, child and youth health and public health policies.

Some existing initiatives to increase the number of Indigenous health professionals and to address the serious under-representation of Aboriginal and Torres Strait Islander people in health professions are proving to be successful and are worthy of expansion. The Puggy Hunter Memorial Scholarship Scheme is one such scheme, offering scholarships for Indigenous students of
Allied Health (excluding Pharmacy); Dentistry; Health Service Management; Medicine; Midwifery; Nursing and a range of Vocational Education and Training (VET) sector courses.

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[4] Tom Calma, in Meet the Press, 0-10 Network, 27 May 2007.

[5] Australian Institute of Health and Welfare (AIHW) (2003). *Health and Community Services Labour Force 2001*, Canberra.

The National Indigenous Cadetship Program is another existing scheme to increase the supply of indigenous professionals. It provides assistance and work placement opportunities to Aboriginal and Torres Strait Islander students. Students need to be studying an undergraduate full-time degree at an Australian tertiary institution.

Aboriginal and Torres Strait Islander Health Workers play a key role in the delivery of appropriate health services to their people and there have been calls for a national registration body and support for a national professional association for this discrete profession. There is a need to extend the availability of competency-based education and training, and to address issues of recruitment and retention within the Aboriginal and Torres Strait Islander Health Worker workforce. National, State and Territory Governments should provide increased and flexible funding to support and expedite the introduction of national qualifications and the agreed new competency standards into all courses for Aboriginal and Torres Strait Islander Health Workers.

6. Infrastructure and service delivery

Health reform needs to recognise that Aboriginal and Torres Strait Islander people are entitled to services that are locally effective, and provide access to the full potential of the Australian health services. As in the wider community, Indigenous health services must be consensual, evidence-based, best practice, flexible and comprised of the most appropriate skills mix.

Services cannot be made available locally without the provision of related physical and human infrastructure, including adequate and appropriate housing. Investment in Indigenous housing in more remote areas must be guaranteed, if not through continuation of the Community Housing Infrastructure Program, then by other well-funded means.

It should be a requirement for all government agencies and others contracted to provide physical infrastructure (roads, buildings, water and power supplies, etc) to offer employment and on-site training and trade-mentoring to local Indigenous people. Examples abound of major infrastructure projects proceeding in areas where there is a large proportion of Indigenous people without taking the opportunity to provide employment and new skills to the local people.

This failure to employ local Indigenous people would presumably be explained in terms of the greater immediate project cost that would be involved. This is symptomatic of a nation obsessed with short-term bottom-lines and unable to see the longer term benefits of investing in human skills and sustainable communities in rural and remote areas.

Given the national shortage of professional skills, there is an immediate conflict between the mining boom in Western Australia and Queensland and the ability of governments and non-government agencies to service Indigenous and other communities in those States. Community services and even commercial businesses are closing because those who run them cannot recruit staff and the proprietors can in any case earn multiples of their income working in the mining sector. Community services find it difficult to meet accreditation standards or to invest because of the shortage of tradespeople. The resource sector itself is not constrained by these factors, using greater numbers of fly-in fly-out workers.

Even some of the pillars of our national health system do not exist in more remote areas. The health reform advocated by AHCRA needs to eradicate the disadvantage for people who are unable to access Medicare because they live in an area without a doctor. Similarly, the inequity that arises through PBS being unavailable to people without access to pharmacists needs also to be addressed. The way health consumers are reimbursed for the costs of travelling long distances to access health services and for child birth is also in need of reform. The need for follow-up care to be available within communities must also be acknowledged. The systems through which people access these financial rights must be simple, straightforward, well-publicised and not lost amid red tape.

Whatever the way forward with health care reform, Indigenous health will continue to require specific recognition and resources, including targeted programs for Aboriginal and Torres Strait Islander patients and their families, as well as for the health professionals who care for them.

A number of targeted programs for Indigenous health already exist, and where these are found to be effective they should be expanded and adapted for new areas and populations where they are likely to be useful. These include the Australian Government's *Primary Health Care Access Program*, the *Healthy for Life* program, investment in the aged care sector, and expansion of the MBS for health care provided by general practitioners and registered Aboriginal and Torres Strait Islander people. The *Healthy for Life* program aims, during the four years from 2005-60, to establish 80 *Healthy for Life* sites, improve early intervention and health service delivery and increase the number of Aboriginal and Torres Strait Islander Australians being trained as health professionals[6].

AHCRA recommendations on Indigenous issues:

1. At all levels, health reform should embrace a broad definition of health, the primacy (or centrality) of the person (patient), a comprehensive view of health determinants, and an inclusive understanding of the health workforce.

2. There should be a whole-of-government response to the Indigenous health differential that recognises the need to work within a broad understanding of 'health' and to address the basic determinants of health as foundational to the success of all other health service provision.

3. Access for Aboriginal and Torres Strait Islander peoples to the following health-related infrastructure and services should be developed as a priority:
   - fresh water, including water fluoridation where viable
   - fresh, affordable food,
   - education,
   - affordable housing,
   - employment opportunities,

[6] Australian Government Department of Health and Ageing (2006)..Healthy for Life., **http://www.health.gov.au/internet/wcms/publishing.nsf/Content/healthoatsih-contact-div-hcsb.htm#pcds**, accessed 3 August 2006.

- health education,
- child and youth health services
- illness management education, and
- adequate housing inclusive of adequate and reliable health hardware.

4. The government should ensure that all Aboriginal and Torres Strait Islander people have access to comprehensive primary care that is culturally appropriate, including:
   - medical care,
   - nursing care,
   - care from a full range of allied health professionals
   - supported mental health interventions,
   - pharmaceutical benefits, and
   - dental care.

5. The government should commit to further incentives and assistance to attract Aboriginal and Torres Strait Islander students to health (and other) careers, including an expansion of the Puggy Hunter Memorial Scholarship Scheme and the National Indigenous Cadetship Program.

6. The government should provide additional support for Aboriginal Health Workers, including more training opportunities and a clear definition of their role in the health workforce.

7. In order to develop effective Indigenous health programs, governments should engage in appropriate consultation with Indigenous groups including metropolitan, rural and remote communities to determine their particular needs, consider and assess proposed solutions, and review existing programs and their relative success in other Indigenous contexts. This will ensure that programs are culturally safe, well supported by Indigenous communities and most likely to be effective.

8. The Australian government should augment and extend programs that focus on Indigenous health, and which are proving to be effective. These include the Primary Health Care Access and Healthy for Life programs.

9. The government should set clear time frames and targets for improvement in Indigenous health so that progress can be measured and strategies evaluated and revised as necessary.

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Australian Health Care Reform Alliance

PRIMARY HEALTH CARE

Government initiatives

AHCRA commends Australian and state and territory governments on their commitment to primary care and their work towards developing new multidisciplinary models of primary care.

Governments have acknowledged that better targeted investment in primary care will lead to improved health for all people in Australia and long term reductions in health care costs. Governments recognise that better integrated primary care services will take the pressure off hospitals and emergency departments.

Features of primary health care

The main features of primary health care services include:

- first-contact access for each new need;
- most frequently used health service;
- long-term person-focused (not disease-focused) care;
- comprehensive care for most health needs; and
- coordinated care when care must be sought elsewhere.

Models of primary health care

Whatever we do, we need to develop new primary health care models that:

- address the social determinants of health and operate within the context of wider population health needs. This will entail the freeing up of funding within the current primary care system so that more resources can be targeted at the non-medical side – including community-based prevention, a greater focus on data collection and analysis to identify individuals at risk and the strengthening of community nursing and the nurse practitioner role;
- deliver effective primary health care - especially to populations that experience access difficulties and/or suffer significant socio-economic and health disadvantage;
- have appropriate community ownership and control;

- be based on integrated multidisciplinary care teams that are either co-located or function as networks of health providers;
- are adequately and appropriately structured and financed to deliver on their core roles and sustain their health workforce; and
- are designed to motivate and build the capacity of consumers to embrace wellness behaviours and confidently engage in the planning, delivery, monitoring, and evaluation of their own personal care as well as health services generally.

There needs to be a "tight/loose" approach to governance:

- tight on outcomes expected by the funder; and
- loose on how local community develops models to best meet local needs.

Government-funded programs need to be well-coordinated, with minimal red tape and a strong focus on the services being delivered and resulting health outcomes.

Australia needs to break down the barriers between federal and state and territory-funded health services. These barriers impede quality care and mean that our patients are put at risk when they cross barriers in our health care system.

Recent research[7] shows that 36% of patients with serious health problems in Australia reported poor discharge coordination accompanying their discharge from hospitals back into the care of their general practitioners, and 23% reported the failure of hospitals to make arrangements for follow up doctor visits.

Benefits of primary health care

A greater emphasis on primary health care in Australia can be expected to:

- lower the cost of care;
- improve health through access to more appropriate services;
- reduce the inequities in a population's health;
- result in earlier intervention into health problems;
- result in more identification of illnesses; and
- mean more emphasis on illness prevention.

Investing in broad-based primary health care is the main way we will:

- contain rising health care costs, especially through support for preventive care, health promotion and improvements in chronic disease management and the management of co-morbidities;
- properly manage the health care needs of the increasing proportion of elderly people in our nation;

[7] International Journal of Health Affairs (Schoen et al, 2005), July 2007.

- tackle the workforce shortages affecting health care provision across Australia, especially through teamwork between primary health care professionals;
- address the continuing rise in mental health problems affecting our population;
- tackle the epidemics of both communicable and non-communicable diseases; and
- ensure that high quality health care is available to all people in Australia, including those who may be disadvantaged.

Social determinants of health

In designing primary health care systems we need to recognise the connection between social determinants of health, prevention and health promotion. Socio-economic factors are some of the strongest influences on health outcomes and cannot be ignored.

Behavioural change programs often fail to reach lower socio-economic groups who frequently have less access to preventive health programs.

This requires consideration by all levels and the different sectors of government – from national to local levels – of the influences on health of policy in diverse areas of government, eg welfare, housing, employment, etc.

Coordination of this is required at the highest level of government and would be facilitated by the proposed National Health Reform Council.

Any reform must enhance equity

Effective measures are required to ensure equity of access to a comprehensive and effective range of primary care services by all people in Australia.

We need to ensure that our primary care services have a focus on meeting the needs of those who belong to specific populations which may be at higher risk or are likely to encounter significant barriers to access.

To this end, we need to support the examination of new models of integrated comprehensive primary care provision to ensure equitable access to high quality primary care for all people in Australia.

Financial Barriers to optimum primary health care

- The distribution of primary health care funding is currently determined predominantly by the distribution of providers rather than by the health needs of the population. This limits the capacity for equitable and affordable distribution of services.
- Funding for primary health care is currently fragmented, coming from three levels of government under a multiplicity of programs. This contributes to both the lack of integration and duplication of services.

- Co-payments limit access to primary health care particularly for those of lower income and may impact negatively on health for those who are at highest medical risk.
- Co-payments combined with fee for service remuneration are one of the contributors to the inequitable distribution of service providers across the nation

AHCRA recommendations on primary health care:

1. What is needed to improve access and equity

We need:

- to address the mismatch between the supply of primary health care services and population needs for primary health care, for instance through direct investment in the establishment of multidisciplinary primary health care services across the country with the first priorities for investment being in areas where access is currently most limited and where the need is greatest;
- greater investment in primary health care models that have been shown to deliver effective primary care to population groups that do not currently receive high quality primary care and who often have the worst health outcomes. These groups include Aboriginal and Torres Strait Island people, people with disabilities, people from culturally and linguistically diverse backgrounds, people living outside the major metropolitan centres and people living on low incomes;
- a review of the impact of patient co-payments on access to primary health care, including GP services, dental services and allied health services such as podiatry, physiotherapy and psychology. The outcomes of the review should inform a rationalisation of patient co-payments to ensure that co-payments, if a role for them is accepted, are never a barrier to a person receiving primary health care;
- a national needs audit at a regional level to form the basis of a needs-based funding model to distribute funds to regions according to needs; and
- integration of funding at the national level through the National Health Reform Council or some alternative national organization in order to move towards both a needs based funding model and an integrated primary care model.

2. What is needed for health promotion and preventive care

We need our Government's recognition that health promotion and preventive health care are core components of the work carried out in primary health care, by:

- funding models which support preventive care and health promotion;
- health promotion campaigns which all include a component identifying how they will be linked to primary care provision, especially to hard to access groups; and
- investment in the time required to deliver quality care.

3. What is needed for a wellness approach

We need to ensure that our primary care system supports individuals to maximize their own health by:

- examination of how we can fund wellness models of health in our communities as well as illness models of health; and
- adequate support for appropriate evidence-based screening activities, and for lifestyle risk factor education, not just treatment services.

4. What is needed to exploit new technologies

We need to examine the potential benefits that new technology, including e-health solutions, may bring to improving the quality and safety of our nation's primary care services by:

- ensuring that our primary care health professionals have ready access to the best available evidence to support clinical decision making - including access to key patient information through shared electronic health records and access to electronic care pathways; and
- embracing and integrating the benefits of new technologies into primary care such as telemedicine and point of care pathology testing.

5. What is needed to ensure system sustainability

We need to work together towards a strong integrated primary health care system by:

- development of policy, principles, and agreed key performance indicators that are adaptable to local circumstances resulting in a diversity of locally applicable models without compromise to accountability;
- adequate resourcing for implementation of primary care policy;
- definition of, and funding for, a range of agreed basic and essential primary care services , especially in allied health, currently receives inadequate public funding;
- planned and sustained funding of primary care services rather than one-off provisions, terminating trials and pre-election initiatives; and
- a focus on resourcing and supporting multidisciplinary teams, networks and co-located services.

6. What is needed for a sustainable workforce

We need to be able to attract the brightest and the best of our young people to work in primary care by:

- expecting a strong commitment by governments at all levels to value the primary health care practitioner workforce;
- expecting a strong commitment by governments at all levels to jointly develop systems which provide appropriate levels of recognition, reward and support for our primary care workforce; and
- ensuring maintenance of the standards for education, training, registration and continuing professional development for all members of our primary care workforce.

7. What is needed for safety and quality

We need to ensure the continuing quality and safety of our system of primary care and that all players, including consumers, work together on improvements by:

- ensuring maintenance of professional standards via the oversight of appropriate professional bodies;
- enhancing the quality of care provided in each location where primary care is delivered in Australia via appropriate clinical quality frameworks and clinical governance;
- including a national program of safety and quality in primary care as part of the work program of the new Australian Commission on Safety and Quality in Health Care; and
- increased support for:
  - quality use of medicines;
  - the management of complex co-morbidities;
  - the rational use of pathology and radiology;
  - a focus on service integration across primary and secondary health care systems; and
  - continuing investment in informatics and connectivity between system elements.

8. What is needed for community groups that require a special focus

If the most substantial gaps in health care access and health outcomes are to be closed, there are a range of community groups that need a special focus including:

- Aboriginal community controlled primary health care services;
- primary care mental health services;
- primary care needs of people with disability, especially intellectual disability;
- early childhood development;
- refugees and people seeking asylum;
- people on low incomes;
- people living in rural and remote areas;
- people from culturally and linguistically diverse backgrounds; and
- oral health reform to integrate provision of oral health services into the multidisciplinary approach proposed in order to address the appalling access to such services for many Australians.

9. What is needed to achieve a National Primary Care Policy and Strategy

We need ….

- an agreed National Primary Care Policy and an accompanying strategy to promote strong planning for the future;
- governments working together to ensure national coordination in primary health care and shared responsibility;

- national policy developed in partnership between governments, consumers and clinicians;
- research and evaluation as integral and ongoing features of our primary care system; and
- policy safeguarding the universal access demanded by the Australian community.

July 2007

Australian Health Care Reform Alliance

INTEGRATION OF HEALTH CARE PROGRAMS THROUGH ESTABLISHMENT OF A NATIONAL HEALTH REFORM COUNCIL (NHRC)

(Initially endorsed by members of AHCRA in November 2005)

Introduction

The jurisdictional inefficiencies associated with the Australian and State Governments being responsible for different segments of our health care system have produced a major problem for which solutions have been sought for, at least, the last 20 years. The current arrangements are now recognised by all as a serious impediment to the delivery of quality, equitable and cost effective health care. They represent a major historical mistake, with the Prime Minister pointing out [in 2004], that were we to design a health care system from scratch we would not make the same mistake again.

The Australian Government is a "purchaser" of health care for Australians and is caught up in a number of open-ended programs, which provide little capacity to tie health expenditure to health outcomes. State governments are 'providers' of services that are partially supported by grants from the Australian Government. It is becoming ever clearer that the lack of integration of the programs organised by State and Federal governments is resulting in an unfortunate and costly amount of duplication and inflation within the health care sector and a lack of capacity to focus on patients' needs. This is particularly problematic when there is a requirement for a horizontal integration of the services by individuals and communities.

The inefficiencies under discussion are responsible for poorer health outcomes than would otherwise be the case, many problems related to the provision of health care across state borders and difficulty in promoting the essential partnership required in Australia between public and private sector providers of health care. In addition, the current arrangements have fuelled a disturbing culture of antagonism between State and Federal authorities rather than the collaboration, partnership and mutual trust needed to continuously improve the health of Australians

Over the last two decades, promises from politicians to fix the problem have not been delivered, as the challenge always seems to fall into the "too hard basket".

Clinicians, consumers and even the Productivity Commission have been very active in urging governments to try again to find a way to abolish these inefficiencies. This urging resulted in the Premiers, Chief Ministers and Prime Minister establishing a COAG working party to advise on ways of resolving this dilemma while providing a reform

agenda to tackle a number of other significant problems. This initiative, backed by the commitment of Australia's health Ministers to promote health care reform, perhaps provides our "last best hope" of finding a way forward.

In this paper we will argue that 'seizing the moment' will require a coalition of the willing involving our community, clinicians, bureaucrats and politicians. A way forward will require political leadership and commitment.

Any suggestion for improving the integration of our health programs in Australia must accommodate a number of political realities. While virtually all commentators agree that on a 'greenfield site' we would construct a health care system organised by the Australian Government, that solution is not available to us in the foreseeable future. Not only are there constitutional difficulties that would have to be overcome, there is also a palpable mistrust between various governments that make it certain that no State Government would relinquish all of its responsibilities to the Australian Government. In accepting these political realities, it's important for all advocates of health care reform to publicly acknowledge that there is no quick fix to our current problems. It is essential that all interested parties accept the concept of a reform journey. Certainly we can, indeed must, have immediate commitment to the journey, the destination and the stops along the way that would make that journey successful.

The journey to health care reform

The longest journey, of course, starts with the first step and that first step must involve action, not rhetoric. History tells us that it is highly likely that even if the COAG working groups were to produce an excellent and politically acceptable raft of suggestions, supported by Australian Health Ministers, those suggestions may remain just that.

For this reason a major, indeed crucial, suggestion from the Australian Health Care Reform Alliance, and no doubt many other organisations that have been thinking seriously about this problem for some time, involves the establishment of a task force to implement health care reform suggestions. It is our recommendation that this task force be constituted as a National Health Reform Council (NHRC), reporting directly to COAG.

Keeping the nation's leaders involved in the journey is crucial as many of the reforms needed involve issues not handled exclusively by the Health Ministers and their bureaucracy. There are, for example, socio-economic factors driving health outcomes that, for resolution, require a whole of government and community approach. While NHRC strategies would require endorsement by COAG, implementation would so often require the cooperative efforts of health ministers that we envisage NHRC activities involving a partnership with the Australian Health Minister's Council. Therefore a first challenge for contemporary political leaders is to see our state and federal leaders support, indeed champion, the creation of this National Health Reform Council.

The National Health Reform Council (NHRC)

Our concept of a National Health Reform Council is that it would have an extended role on the Australian health care landscape remaining active for at least the next few years. The demands on health care systems around the world, with ever improving technology, the rapid aging of the population, constant challenges from new disease entities and the

re-emergence of more serious infectious diseases makes it likely that an instrument that could facilitate our rapid adaptation to changing requirements makes perfect sense. The sustainability of the health care programs that we desire in Australia will require a continuing effort and major oversight to ensure that cost effectiveness is achieved with the dollars spent actually producing desired outcomes.

For this reason, we see the NHRC as a living, breathing, full time, innovative, well resourced, transparent, inclusive, semi independent and dynamic entity. Its role would be to implement reforms approved by COAG and/or the Health Ministers' Council. It would involve the establishment of a new agency but it would not require any increase in our bureaucratic workforce.

All jurisdictions have in their Departments of Health, knowledgeable and talented professionals who work on the interactions of State and Federal Governments pursuing health care programs while others are involved in the most important issues an NHRC would tackle on an ongoing basis, namely workforce, manipulating our health care resources to provide more of a "wellness" model and the fusion of state and federal programs. Bringing together these talented individuals, in partnership with consumers and clinicians, would make it possible to reduce significantly the number of bureaucrats involved in delivering health care to Australians.

The NHRC would be charged with taking Australia on the reform "journey" we will outline. We suggest that the NHRC would be led by a chief executive officer and be staffed by bureaucrats with the experience mentioned above. Crucially, the Council must have full time clinical and consumer involvement.

Mission of a National Health Reform Council

There is little controversy in Australia that there are three major issues that must be addressed as we promote health care reform:

1. the provision of an adequate workforce;
2. the development within Australia of a health system promoting 'wellness', the prevention of disease and earlier diagnosis to minimise the development of chronic disease; and
3. the integration of current and future health care programs to increase quality and therefore better health outcomes while addressing issues of cost effectiveness.

We argue strongly that these three issues cannot be addressed independently.

Workforce

The National Health Reform Council would be charged with implementing any accepted recommendations coming from the work of the Productivity Commission on workforce issues. A major deficiency in the draft recommendations involves the lack of integration of workforce planning with the future models of care that will be required to address the needs of contemporary Australia.

The NHRC, by addressing simultaneously all the issues mentioned above, would be able to solve this problem.

The Productivity Commission is currently calling for four new programs to be introduced to improve recruitment, training and many other issues related to the Australian health care workforce. All of these programs should of course, be integrated and this would occur within the NHRC.

The National Health Reform Council will supply leadership in the development of plans for a specific increase in the number of university positions needed to train our workforce into the future, an area not tackled in the PC draft report. A workforce plan must ultimately accept the need for us to be self sufficient in terms of supplying the workforce Australians need for their health care system. Indeed, many would argue that we have a responsibility to train sufficient health care professionals to assist with the improvement of the health of peoples in the countries surrounding us.

Primary care

A wellness model requires new methods for primary care delivery in Australia. Virtually every other OECD country with which we would like to be compared is moving rapidly in this direction. Those countries having most success have a major advantage over Australia in that they have a unitary source of funding which makes it so much easier to see health care dollars redistributed to produce new models of care.

What is clear in Australia is that if we are to successfully introduce new models for primary care delivery we must have State and Federal Government collaboration and partnership to achieve our goals. The NHRC would be the ideal vehicle to pursue this partnership. In taking Australia on the journey towards a wellness model of health care delivery, the NHRC will be charged with, in partnership with clinicians and consumers, helping us introduce better 'organised primary care'.

The NHRC will promote, with State and Federal Government cooperation, the establishment of Integrated Primary Health Care Organizations featuring a "team medicine" concept critically involving a far more mature approach to clinical role delineation than currently exists. These advances will provide us with a better capacity for health promotion and the prevention of avoidable disease, earlier intervention to minimise the onset of chronic disease and the capacity for clinicians to care for more people in a community and home setting, rather than in a hospital. One of the goals of the NHRC would be to reduce our hospital-centric approach to health care.

Affordability

Current inflation within the health care system is reported by many to be economically unsustainable. The lack of a partnership between private and public sector deliverers of health care is resulting in major cost inefficiencies while the open ended-ness of the MBS and to a lesser extent the PBS, are all putting enormous pressure on state and federal treasuries. There is an enormous amount of data demonstrating that health care reforms of the type we are proposing will minimise many of these problems. The National Health Reform Council will be able to pursue the "win-win" needed in Australia, namely improved health care for Australians with the currently available dollars. Minimising duplication would be a priority.

The NHRC would facilitate the more rapid introduction of electronic health records and champion the introduction of clinical governance techniques into primary care.

Engaging Australians in the reform journey

Very importantly, the NHRC would lead initiatives which would see us engage the Australian community in a significant and detailed dialogue about health care into the future. The NHRC would implement programs that would engage, inform, listen to and empower the Australian community to provide direction for, and embrace, necessary reforms.

Integrating state and federal programs

The NHRC would be responsible for taking us on that part of our reform journey that would see an ever-increasing integration of state and federal programs. Thus the NHRC could be involved in assisting with the development of bilateral, and even trilateral agreements between Australian governments around specific programs.

Examples would include the integration of primary and community care services, the integration of cross border programs to solve many current inefficiencies and the fusion of numerous state and federal programs all aimed at improving the care of older Australians. The Commonwealth would always be a partner in these bilateral and trilateral arrangements and the NHRC would promote the notional, or real, pooling of funds to achieve the goals of the fused programs.

Importantly, the NHRC would establish and evaluate the governance mechanisms set up for each of these joint ventures. In this way, we would learn as we proceed along our journey what safeguards produce appropriate comfort zones for state and federal governments, making them more confident into the future that they can, through collegiality and partnership and a determination to focus on the needs of the community, end many of the jurisdictional inefficiencies that currently exist.

The partnership that we need between federal and state governments must be supported by efforts to promote and evaluate partnerships between the public and private sector deliverers of health care in Australia. The NHRC would be charged with driving these initiatives as well.

What awaits us at our destination?

It is conceivable that over the years of a journey that would produce continuous improvement to health care in Australia, political leaders and the community alike may decide on a central government assuming responsibilities for all aspects of health care. We believe it is more likely that the journey would see the exploration of the formation of an Australian Health Care Corporation, a third party that would run the Australian health care system on behalf of both state and federal governments, reporting through COAG to parliaments and therefore the Australian people.

What is clear is that a National Health Reform Council utilising the best talents available and recognising the need for much discussion and research as we continuously improve our existing programs, would be best suited to developing those models into the future

that would provide Australians with the superb health care system we deserve and can afford.

The commitment to reform and the establishment of an NHRC to provide leadership for that reform would generate public enthusiasm for the approach.

AHCRA recommendation on integration of health care program

AHCRA recommends the establishment of a National Health Reform Council (NHRC). The NHRC will implement health care reforms approved by COAG and/or the Health Ministers' Council.

The National Health Reform Council will coordinate programs in partnership with clinicians and consumers to reduce the staff required to deliver health care to Australians.

COAG should establish a working party to determine the terms of reference for the National Health Reform Council.

The National Health Reform Council's mission should reflect the following reform priorities:

- the provision of an adequate workforce;
- the development of a health system promoting 'wellness', the prevention of disease and minimization of chronic disease; and
- the integration of current and future programs to increase quality and therefore better health outcomes while addressing cost effectiveness.

Australian Health Care Reform Alliance

THE NEED FOR DIALOGUE WITH CITIZENS AND CONSUMERS ABOUT THE FUTURE OF THE AUSTRALIAN HEALTH SYSTEM

1. Introduction

This paper proposes that in order to create a sustainable Australian health system of the future, which is both integrated and can meet the myriad of consumer and financial pressures on it, there needs to be meaningful national dialogue with citizens and consumers. Such a national process will create a common set of values, principles and priorities to guide the development of the Australian health system by all governments.

2. Rationale

There are multiple pressures placing the Australian health care system under increasing strain. The key issue is how to manage increasing demand in a sustainable way in the face of often intense financial and resource pressures. There is little doubt that the system cannot continue as it currently is. Serious reform of the health system must be on the agenda at both state and national levels.

Many people in the health system are required to make complex and difficult resource allocation decisions with long-term implications. Often this may mean having to prioritise:

- some care approaches over others (eg more prevention or more treatment)
- some treatments over others (eg more high technology interventions over low-tech)
- some conditions over others (eg those easily treatable vs. those expensive to treat, especially with medications)
- some populations over others (eg well-off vs. poor, younger people vs. older people).

Decisions about the use of resources, whether at a patient-by-patient, program-by-program, or service-by-service level, are often piecemeal. While there needs to be discretion about how resources are used at these levels, piecemeal and ad hoc resource allocation decisions at the whole system level is both inefficient and likely to lead to suboptimal outcomes.

Given the significant challenges the system is facing, crucial medium and long-term decisions that apply across the whole system are required. The fact is, however, that these are often very complex and difficult decisions for governments to make in the

interests of the community, so that governments can shy away from actually making the necessary decisions.

It is on such critical issues as these that dialogue with citizens and consumers will assist governments in making these decisions. As governments consider difficult and at times unpalatable choices on health care, policy needs to be informed by ordinary "unorganised" citizens, as well as powerful "organised" interest groups. The public needs the opportunity to "work through" conflicting values and difficult choices in order to reach judgments.

3. What is citizen and consumer engagement?

The Health Canada Policy Toolkit describes citizen engagement as the "*public's involvement in determining how a society steers itself, makes decisions on major public policy issues, and delivers programs for the benefit of the people. Citizen engagement is closely linked to the concept of social cohesion. Social cohesion refers to the building of shared values, reducing inequities, and enabling people to have a sense that they are engaged in a common enterprise and face shared challenges as members of a same community.*"[8]

The future of health care and the big-picture resource allocation and priority decisions required, are exactly the kind of major public policy issue that would justify citizen and consumer engagement. After all, it is citizens who use health services and pay for them.

The engagement process we propose will involve citizens and consumers in a structured, transparent, information-rich, deliberative and meaningful process (described in more detail below). This contrasts with the more common policy development processes, which privilege the organised stakeholders; for example peak bodies of providers, professional associations, commercial interests, lobbyists, and other interest groups.

In order to get a balanced picture from the community, citizens' perspectives need to be augmented by the extra insights of two other groups: those who use the system the most (e.g. those with chronic conditions) and those who often miss out on health services.

4. Why do we need to engage the community?

There are several reasons for engaging the community.

1. Citizens and consumers have a legitimate expectation to have a say in the future shape of the health system because they are ultimately both the users and the funders of the system.
2. Informed and deliberative advice from citizens and consumers, especially about the underlying principles, values and priorities for a future system, will be of great value to politicians in making sense of the more technical and sometimes vested interest advice they will receive from those within the system.
3. Citizen engagement helps to clarify how deeply-held values are evolving with changing circumstances. Values play a central role in deciding which problems should have the highest priority, which options are acceptable, and in shaping the solutions we choose to adopt.

[8] Health Canada (2000), Policy Toolkit for Public Involvement in Decision Making, prepared by the Corporate Consultation Secretariat, Health Policy and Communication Branch, Ottawa.

4. The timing is right for developing such nationally applicable tools. There is almost universal agreement by most major stakeholders that some big, critical decisions are required about the shape and priorities of our future health system. At such an important moment, many more people than the 'usual list of suspects' need to be involved.
5. Unless governments involve the community in setting priorities in health spending, we will not make real progress in systemic reform. The community must be locked in through appropriate structures and processes or health reform will not happen.
6. Policies and changes based on the transparently garnered values of the public will be much easier to put into practice. Indeed, the legitimacy and sustainability of most important public policies depend on how well they reflect citizens' values.
7. It will increase public awareness about the difficult choices of health prioritising in a resource–constrained environment and build consensus and greater community trust and hence decrease the fear factor when change is implemented.

5. What type of national consultation are we proposing?

We are proposing that the Federal and State Governments jointly run a national engagement process with citizens and consumers, aimed at eliciting some consensus on the main values, principles and priorities for the future of the Australian health system.

The process would be strategically aimed at involving random samples of citizens drawn from the general population, high users of care, and traditionally hard-to-reach groups (eg Indigenous people, homeless people, people with disability).

The process would be based on the following principles:

- The approach must be seen as **non-partisan and legitimate** by the key stakeholders, especially funding governments, before the process starts (otherwise it will be of limited value).
- The process should be **transparent**, accessible and accountable and run by an independent organisation.
- Participants will need to be **well-informed**, for example provided with good quality information on which to offer opinions and to share their values. This stage might also include a public awareness campaign to stimulate interest in the engagement process, including a website where factual information about all sides of the issues is accessible, and information about how participants are to be selected or accessed.
- The process should be **deliberative**, that is people will get the chance to discuss the information provided, ask questions, put forward their own views and listen to those of others before being asked for their views. Typically they may be given concrete problems, with resource and other constraints to solve and make decisions on (i.e. not just produce a wish list), and then be asked to analyse the underlying principles and values used to make their final decisions.
- The process should be **meaningful**, that is linked to a genuine policy development and decision-making process.
- The process should use a **variety of methods** and triangulate findings, that is seek the common themes and positions found across all methods, so that different populations or methods do not bias results.

- The process is sufficiently **resourced and well-facilitated** so that it can be organised properly and generate good quality results.
- People's contributions are respected and participation is **non-burdensome**.

It should be acknowledged that public engagement, as often undertaken, can be problematic. For example, it can be:

- resource intensive;
- inaccessible for those who are poorly connected to established authorities and systems;
- influenced by those who manage it; and/or
- dominated by the best resourced and skilled advocates.

These traps can be avoided if they are openly addressed and safeguards built into the process design.

6. What questions would we pose?

One of the most challenging aspects of the process will be to gain agreement on what it is we want to know from citizens. Firstly, this involves defining the issues and their scope. Secondly, it involves 'framing' the actual question/s to be asked and explored that will elicit valuable responses to the overarching issue. Most of the methods it is possible to use seek in-depth responses to very concrete problems, as these are easier for the average citizen to answer. Such problems should involve prioritising benefits/outcomes so as to be realistic and provide information useful to decision-makers. However, as noted above, the processes should also explore the underlying values and criteria that participants use to come to their decisions. The latter information is likely to be the most valuable to decision-makers.

Some of the broader issues that could be addressed using the methods outlined in this paper include:

- What are the values or principles you believe should underpin and drive funding and services of the Australian health care system? What should get priority when budgets are constrained?
- What is the right balance between health spending on treatment as distinct from prevention?
- Should health care in Australia be universally and freely accessible on the basis of need, "adequately" funded by tax dollars, or should there be a two-tier health system that encourages people to pay for as many health services through the private system as possible, and the public system to cater for those unable to pay?
- If we do not have adequate supplies of health professionals for our current configuration of services and roles, is it reasonable to train more lesser trained staff to assist the professionals?

Such contentious discussions would enable participants' underlying values to emerge, and be collated.

7. Methods

No one consultation mechanism is perfect and each method has its bias, and hence both the literature and experience recommends the use of a complementary combination of methods, say, three or more. It is also critical that the technique suits the purpose of the engagement. Further, new mechanisms for community consultation and participation have emerged and been developed in recent years.

Such methods include citizens' juries, citizens' deliberative councils or citizens' assemblies, consensus conferences, world cafes, deliberative polls and televoting. All rely on talking to a cross-section of people, the provision of good quality information to participants, and a deliberative process (ie one where participants get adequate time to discuss and think through the issues).

8. What needs to happen next?

The Australian Health Care Reform Alliance (AHCRA) has undertaken its own small-scale community consultations to garner the views of citizens and consumers on their experiences of the health system and the values and priorities they would like to see reflected in the health system. (A presentation will be given on this process at the Summit on Reform in the Australian Health Sector on 30 July 2007, and a paper made available).

The Alliance undertook this work to demonstrate the effectiveness of citizens' engagement and to help build a political consensus among Australian governments about the need to start collaboratively exploring the parameters of a plan for a meaningful national engagement process.

July 2007

Australian Health Care Reform Alliance

AUSTRALIA'S HEALTH CARE WORKFORCE

The Australian Health Care Reform Alliance's objective in relation to the health workforce is to improve access to safe affordable health care from a safe and sufficient workforce.

AHCRA believes national workforce planning, based on nationally collected statistics, would deliver greater certainty with regard to the availability of health services, improve access to care, and is essential to deliver the better health outcomes that Australia is capable of delivering and can easily afford.

Maintaining the health and wellbeing of the Australian community requires ensuring the provision of an adequate number of appropriately skilled and educated health professionals to provide the care the community requires to maintain optimum health.

To achieve this aim in Australia today, we need a significant increase in the investment being made in the education of health professionals. AHCRA believes that health care is a right and should be available on the basis of need not the ability to pay – but without an increased investment in the education of health professionals, Australians will continue to struggle to gain access, in a timely manner, to services that maintain and support health and offer quality health care to those in need.

Achieving sustainability in the health workforce can only be accomplished if fundamental structural changes are made to the way health care is funded and administered.

We believe a whole of government approach is required to address the immediate demands on the health workforce. This requires the allocation of substantial additional funded places in the higher (both undergraduate and postgraduate) and vocational education sectors; sufficient funding to ensure satisfactory clinical placements are able to occur; the introduction of improved strategies for entry, retention and re-entry to the health workforce; and an increased emphasis on teaching and research, so crucial to quality care.

There is an urgent need to establish an effective mechanism to link workforce demands with the funding of education for the health workforce.

Health workforce planning also ensure the education of health care professionals consider the need for culturally appropriate services to cater for the diversity that characterises modern Australia.

Currently there are significant pressures on the health workforce, including an inadequate mix of skills and capacity, and critical shortages in many disciplines.

There are insufficient numbers of nurses, doctors and allied health professionals in Australia, to meet the health care needs of the Australian community. The average age of nurses in Australia is 47 years old, and many may well retire in 10-15 years leaving our already understaffed nursing workforce on the brink of collapse. We need to double the current annual intake of nurses in order to meet the nursing care demands of our ageing population – as it is a shortage of education places, not a lack of demand that sees more than between 2,000 eligible applicants turned away from nursing education courses each year.

As well as an insufficient numbers of doctors, there is poor distribution of the medical workforce which sees many Australians struggle to access the services of a doctor.

Many more higher education places are required to meet the needs of our community. However this should not include the recruitment of health professionals from overseas, as many come from countries whose health systems can ill afford to lose them. AHCRA believes Australia should be training enough health professionals to meet our own health care needs, as well as the needs of our regions, if and when required. AHCRA strongly supports self sufficiency in the health workforce as well as developing extra capacity over time to support other countries in our region.

Meeting the current and future needs of the health workforce requires careful planning. For this reason AHCRA supports the development of a national workforce policy for Australia that aims to train enough Australians to care for our health needs.

AHCRA supports the establishment of a single agency, such as a National Health Reform Council, to ensure coordination between health workforce requirements and education of the health workforce.

One of the key elements of national health workforce planning is the number of professionals being prepared for the workforce, and the means by which this happens. These matters are the responsibility of the education sector, however improving the links between health and education would ensure the national demand for services is able to be met.

Good workforce planning has the capacity to improve job satisfaction by enhancing the match between individuals and their skills, and ensuring manageable workloads in the jobs they undertake. This in turn results in greater productivity and lower turnover. Increases in productivity in the health sector are both feasible and desirable, as indicated by the Productivity Commission. For its part, reduced turnover will reduce the need for training and retraining of new staff.

There is also a potentially significant international benefit from improved workforce planning. Currently, the Australian health sector relies to a substantial extent on overseas trained health professionals. Through workforce planning, Australia can make explicit its desire not to actively recruit health professionals from less affluent nations, and also reduces overall demand for health professionals by making better use of those it has.

However, delivering better health care demands not only a sufficient workforce, but also models of health care that are efficacious and cost-effective. Cost-effective health services are those that deliver the greatest returns in health for each dollar invested.

There is little argument internationally, or among most health professions, that the most cost- effective and efficient care is provided to patients by multidisciplinary teams. Not only do these teams produce high quality care, but they also deliver considerable gains in terms of professional satisfaction for those involved, positively impacting on the retention of practitioners. This has the obvious benefits of maintaining and developing a highly skilled workforce and is also essential in minimising the turnover costs and additional educational costs associated with the early exit of dissatisfied professionals.

The Alliance believes that due to the divided responsibilities for health care administration, service delivery, and funding between federal and state/territory governments that high-quality planning of the health workforce is unlikely to be achieved under current arrangements. What is required is a collaborative effort by federal, state and territory governments to develop national workforce planning and management systems that can appropriately predict workforce demands and equitably fund the education for health professionals required to meet that demand.

It is the position of the Australian Health Care Reform Alliance (AHCRA) that:

1. As a wealthy country, Australia should be educating enough health professionals to meet the health care needs of the national population as well as developing extra capacity over time to support other countries in the region in which we live.

Planning

2. Improvements in strategic workforce planning are essential to improve the provision of health care to the Australian community through safe and efficient care from a safe and sufficient workforce.
3. A whole of government approach, i.e. federal and state and territory governments working cooperatively together, is vital for effective national health workforce planning.
4. High level linkages are needed between health and education departments at federal, state and territory level to ensure effective national workforce planning.
5. The way the health workforce is educated, regulated and works is inextricably linked to the way health care is funded and provided and effective workforce planning can only be achieved if structural changes are made by government.*that isn't clear
6. Engagement of the community who are the recipients of care and well as the clinicians who provide the care in workforce planning is essential if maximum benefit from available funds is to be obtained.
7. Effective workforce planning must include requirements of the specialist health workforce, that of the Indigenous health workforce, and the needs of people in rural and remote communities.

Recruitment and retention

8. The federal, state and territory governments should work together to develop and introduce effective strategies for entry, retention and re-entry to retain health workers already in the workforce.
9. Strategies to improve recruitment and retention in rural and remote areas should specifically focus on removing the inequities that exist between medicine and the other health professions, particularly nursing, allied health and dentistry, in the incentives available to encourage rural and remote practice.

Safety and quality

10. Safety and quality should always be paramount in the consideration of options for the development of a more flexible and effective health workforce.
11. Workforce innovation must be driven by, and supported by, evidence, not cost saving.

Education

12. An urgent response from the federal government is required to meet the immediate needs of the health workforce - this involves the allocation of additional funded places in the higher and vocational education sectors.
13. An additional 1,000 undergraduate nursing places must be made available each year for the next five years to address the current and predicted shortfall in that profession;[1] there should be an increase in medical training places consistent with AMWAC recommendations;[2] an increase in undergraduate places for allied health professions where there is a demonstrated shortfall in supply;[3] and an increase in retraining places available for nursing and allied health professionals to assist those who have been out of the health sector to return to work as safe and competent health professionals.[4,5]
14. Funding for all education for the health workforce – both theoretical and clinical – should be equitable across the professions, that is, at the same level as medicine.
15. There should be funding incentives for interdisciplinary education at undergraduate and postgraduate levels to improve understanding and cooperation between the health professions.
16. Funding should be provided to health facilities to employ staff specifically to support students and vocational trainees and facilitate their clinical training.
17. Investment is urgently required into more interactive laboratory learning, clinical simulation and new models of clinical education.
18. Health care facilities of all types require support so that they can coordinate all clinical training occurring at their facility.
19. Incentives should be provided to facilitate access to a broad range of clinical placements for students of the health professions, for example in the private sector, the community, non-government sector and aged care sectors.
20. Access and affordability of clinical education for students (undergraduate, postgraduate and vocational trainees) at rural universities and for students undertaking rural and remote clinical placements must be urgently addressed.

Funding

21. Transparent review and evaluation of access to Medicare and the MBS is strongly supported, both in relation to innovative funding models and access to rebates for services delivered by a wider range of providers who have an appropriate scope of practice and who meet appropriate standards of practice.
22. Rebates for delegated services should increased e.g. the rebate for nurses and other health practitioners for referred services from general practice is too low and does not compensate the practice adequately.

* The term 'health care' in this paper is used in its broadest sense, and is inclusive of: promoting health and preventing ill health; acute health care, rehabilitation, care for people with disability, care for young people, families, people with alcohol and other drug issues, people who are dying, maternity care, mental health care, aged care; in all settings: acute hospitals, people's homes, residential facilities, workplaces, schools etc; wherever people live: cities, outer metropolitan areas, rural areas, remote areas.

July 2007

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Australian Health Care Reform Alliance

PRINCIPLES AND PROGRAMS FOR RURAL AND REMOTE COMMUNITIES

Summary

AHCRA has agreed that the key problems with the health system as a whole are:

- more and more Australians are finding themselves unable to access or afford health care when and where they need it;
- there is a chronic shortage of doctors, nurses, allied health professionals, dentists and other health professionals, with the worst shortages being in rural and remote areas;
- there is insufficient focus overall on the need for primary health care such as health promotion and illness prevention as the need to service acute care increases;
- the current State/Commonwealth funding structure leads to inefficiencies, uncertainties and inaction; and
- there is a lack of national commitment to fundamental reform.

In one way or another all of these concerns relate to non-metropolitan areas. Some of them are indeed more serious in those areas, such as the workforce shortages and affordability of care when travel and accommodation has to be included, despite the fact that morbidity and mortality are worse there. For these reasons, AHCRA has given some attention to how potential reforms to the health system would impact on people in rural and remote areas.

An improvement in funding mechanisms for the national health sector will significantly enhance health services and outcomes in rural and remote areas. AHCRA is interested in further evaluations of such concepts as pooled funding nationally and needs-based funding regionally. Without significant structural changes to the funding of the health system, rural and remote health services are likely always to be playing catch-up and to be at the mercy of budget and program cuts.

Rural issues in 2005

For the AHCRA Summit held in Adelaide in 2005, its rural and remote committee focused on:

- better capacity building and education and training to provide further incentives and flexible training for health professionals;
- improved support and mentoring to international health graduates in rural areas;
- national registration and mutual recognition of qualifications across the States;
- the need to maintain health infrastructure in rural areas; and
- the need for special services for those who do not have access to services funded by Medicare.

There remains much unfinished business in relation to these issues.

AHCRA's 2007 statement on rural, regional and remote areas

Regardless of income, education, culture or geographical location, Australians have a right to accessible health services according to need. People in rural, regional and remote areas are currently among those most adversely affected by poor access to health services, poor continuity of care and lack of early detection /screening programs coupled with the lost opportunities for clarity and collaboration between the levels of government.

Thirty per cent of Australians live in rural Australia, including the 3 per cent in remote regions. People in these areas have poorer health outcomes and a higher incidence of risk factors. These risk factors include poor nutrition, inferior health-related infrastructure, little access to specialist services, high rates of smoking, alcohol and other drug misuse, and inappropriate attitudes to risk-taking behaviours.

A man born in far western NSW can expect to live 13 years less than one born in Mosman, Sydney. One reason for this is that poor access to health services results in less timely interventions or early detection, and therefore lower rates of recovery and survival. A similar incidence of illness or accident could therefore result in worse effects for people in rural and remote areas than for people in the major cities and therefore longer recovery periods are needed.

The principles being promoted by AHCRA will improve access to health services for rural people and thus help them to obtain ‘a 30 per cent fair share’ of health resources. AHCRA’s proposals will also improve the efficiency of national health expenditure. These things will, in turn, ultimately improve the health of people in rural and remote areas.

Rural and remote communities are extremely diverse, and a ‘one size fits all’ approach is not effective. Some rural and remote areas are already taking the lead in breaking down a silo approach to health, including in workforce education and training, in funding models, integrating practice nurses into general practice, delivering health services through multidisciplinary teams, and working effectively across jurisdictional boundaries.

A number of these innovative programs were showcased through papers to the 9th National Rural Health Conference (Albury, New South Wales, March 2007).

Whatever changes are effected in health systems, access, safety and quality remain paramount. A second-class system for rural or remote areas is not acceptable.

Because some 70 per cent of the nation's Indigenous people live in rural, regional and remote areas, the Indigenous health emergency is in part a rural and remote issue. As long ago as the 1830s it was suggested by some in authority that "the very first use of revenue generated from the land should be for the amelioration of the Aboriginal condition". The same spirit imbues the current national strategic framework for rural and remote health, Healthy Horizons, which ranks national work on the Indigenous health challenge as the most important and urgent issue of all.

The latest developments in policy approaches to Indigenous health, focusing as they do on the Northern Territory, illustrate that to a significant extent the Indigenous health challenge is a non-metropolitan issue. The rural and remote health sector includes substantial Aboriginal and Torres Strait Islander interests, and improvements in health services in rural and remote areas are inextricably linked with Indigenous health outcomes. (There is a separate AHCRA position paper on improving Indigenous health.)

Where there is no doctor, there is no access to Medicare. The Medicare deficit in rural and remote Australia has been estimated at $400 million a year. Political recognition of this deficit (and a similar one for the PBS) underpins the provision of special programs for rural and remote areas, many of them targeted at rural general practice. These special programs (eg rural GP strategy, Regional Health Services, University Departments of Rural Health and Regional Clinical Schools, support for the RFDS) need to be sustained.

AHCRA welcomes the fact that some of the successful approaches to rural general practice (eg rural scholarships) are being adapted for non-medical professions. Its general position is that more needs to be done to extend such incentives for recruitment and retention to nursing, allied health, dentistry and pharmacy so that there is much greater equivalence between the various professions. It is widely understood that doctors will not and cannot serve on their own in rural and remote areas; greater effort needs to be made to build up the multidisciplinary health team, including through the expansion of alternative models of care and mobile primary health clinics.

Impacting on rural and remote health workforce recruitment is the availability of entry level education and training for health professionals in these areas. University cluster funding through the Department of Education, Science and Training for the allied health professions does not reflect the clinical education requirements for these courses.[9] Lack of support for rural education, such as is available to the medical discipline through DEST cluster funding and Department of Health and Ageing programs such as Rural Clinical Schools and the RUSC program, is impacting on the ability of universities to provide allied health and nursing students with rural and remote clinical placements.

[9] Further details are provided in the submissions by SARRAH and Allied Health Professions Australia to the DEST Review of the Higher Education Support Act, 2003.

Integrated models of care are most effective in many areas of health care provision, such as for maternity services and mental health. In the latter, for example, there need to be health teams in rural and remote areas with adequately trained and resourced specialist mental health workers, rural doctors, support for carers, and IT to enable interaction with specialists from outside the area.

Whenever there are workforce shortages they are most severe in rural and remote areas, where the majority of 'hard to fill' vacancies exist. The recent COAG reforms moving Australia towards a national registration scheme for nine health professional groups will help, because of the frequency with which members of the rural and remote health workforce (including locums) cross borders. ACHRA recommends that the health professional groups currently not included in this scheme due to their requirements to be registered only in some States, work with the national registration body to obtain national registration as soon as practical.

'Workforce redesign' in the health sector is an issue with which Australia must come to grips. In doing so, the quality and safety of service and health outcomes must be protected. Done well, redesign will enhance recruitment, retention and job satisfaction, especially in rural and remote areas.

In rural and remote areas, 50 per cent of the health workforce are nurses. There are currently serious supply and retention issues in nursing. The Productivity Commission estimated an immediate 2.2 per cent nursing shortfall. This may be an under-estimate given AHCRA's belief that single nurse posts in rural and remote areas are not safe and should be replaced by a team approach to care or mobile clinics

Remote areas have some very particular needs and often need to be distinguished from regional areas. In remote areas, funding consideration needs to encompass a region, not a locality. Funding and structures need to provide for flexible service, with employment on a regional basis, and with an emphasis on comprehensive primary health care, health promotion, prevention, early diagnosis, child and youth health programs and food security. Services must not be allocated on a population base, as population based benchmarking does not take into account distances that must be travelled by either the professional to deliver the service or the consumer to access the service in remote areas.

AHCRA recommendations on rural and remote health:

1. People in rural and remote areas will be among the main beneficiaries of enhancement of the universality of Australia's health-care system. A two-class system across any spectrums (metropolitan-rural, rich-poor, black-white) is not acceptable. **Governments should commit to equivalent services and equal health for people in rural and remote Australia by 2020.**

2. The rural and remote health sector, led by its Aboriginal and Torres Strait Islander constituents, is a key player in activity to improve Indigenous health. **Partnerships must be developed between Indigenous health interests and governments, including in rural and remote areas, to implement and manage programs designed to put in place sustainable health systems for Indigenous people.**

3. National health workforce initiatives must continue to pay particular attention to the severe shortages of health professionals in rural and remote areas. **Recruitment, retention and educational and training incentives must continue to be supported for rural doctors and specialists, and extended to nurses, allied health professionals, dentists, pharmacists, Aboriginal Health Workers and health service managers.**

4. Community consultation is even more important in rural and remote areas where information is sparser and its communication more challenging. **Governments at all levels, and their health service operations, must engage in meaningful community consultation in rural areas and provide relief funds required to make it effective.**

5. Some of the most innovative and successful integrated health care teams are in rural and remote areas. **Once there is evidence that they are clinically effective and economically justifiable, sustainable government funding should be provided for health services in rural and remote areas without requiring multiple accountability systems and without requiring constant re-trialing and resubmission.**

6. It is valuable to have an agreed strategic framework for rural and remote health. **The Australian, State and Territory Governments, in conjunction with the National Rural Health Alliance, should agree on a new strategic framework for rural and remote health to succeed *Healthy Horizons*, and all jurisdictions and professional bodies should use the new framework to evaluate their own activities, and as a means of setting priorities.**

7. National registration of health professionals (currently under consideration for a group of nine professions) would be particularly valuable in rural and remote areas. **The Council of Australian Governments (COAG) should continue work to ensure that, as soon as possible, national registration or, at least, mutual recognition of registration, is a reality in the Australian health sector.**

8. It is important that there be a good evidence base on rural and remote health, including on workforce numbers, morbidity and mortality, and the effectiveness of various approaches to the provision of services. **The major health research bodies, such as the NHMRC, the ARC and the AIHW, should allocate a fair 30% of their research effort to rural and remote issues. Wherever possible, such research should be undertaken in rural and regional areas, and by rural and regional people.**

9. Wherever it is not possible to provide local services, such as those provided by specialists and those related to maternal and child health, equity demands that rural and remote people have the costs of accessing such services at a distance reimbursed to them. **Patients' accommodation and travel support schemes should have uniform eligibility and payment systems, and be funded in each jurisdiction to the level required to provide support to all eligible applicants.**

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Australian Health Care Reform Alliance

Members of AHCRA

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Audiology Australia
Australian College of Midwives
Australian Council of Social Service
Australian Health Promotion Association
Australian Healthcare Association
Australian Nursing Federation
Australian Rural Health Education Network
Australian Salaried Medical Officers Federation
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Catholic Health Australia
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CHOICE
Chronic Illness Alliance
Combined Pensioners and Superannuants Association
Continence Foundation of Australia
Council of Remote Area Nurses of Australia
Country Women's Association of Australia
Doctors Reform Society
Frontier Services of the Uniting Church
Health Consumers' Council (WA)
Health Consumers Network
Health Issues Centre
Health Reform South Australia
Maternity Coalition
National Aboriginal Community Controlled Health Organisation
National Council For Intellectual Disability
National Public Hospitals Clinicians' Taskforce
National Rural Health Alliance
NSW Nurses Association
OT Australia
Public Health Association of Australia
Public Hospitals, Health and Medicare Alliance
Redcliffe-Bribie-Caboolture Division of General Practice
Royal Australasian College of Physicians
Royal Australian College of General Practitioners
Rural Doctors Association of Australia
Services for Australian Rural and Remote Allied Health
South Australian Salaried Medical Officers Association
Tasmanian Medicare Action Group
Victorian Medicare Action Group