Australian Health Care Reform Alliance

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Professionals and consumers agree on key health reforms

The Australian Health Care Reform Alliance (AHCRA), which met in Melbourne this week to consider recent reforms proposed by the National Health and Hospitals Reform Commission (NHHRC), has found that while the Commission has some elements right its recommendations fall short on several crucial issues.

"The Alliance congratulates the Commission for much of its work but feels it could have gone further in the reform process," said incoming AHCRA Chair, Tony McBride. "We are highly supportive of proposals for one national health system – not eight systems funded by nine governments as we currently have.

"We also unanimously welcome the stronger focus on primary health care, provided by multi-disciplinary integrated services. However, many members thought these services should move away from a predominant reliance on fee-for-service and consumer payments, towards a blended system with significant payments for the total health care needs of a population, based on voluntary enrolment," Mr McBride said.

The Alliance, which is a collaboration of 50 national and state health organisations representing an estimated 500,000 health consumers, health professional and health service providers country wide, was less supportive of the main funding options proposed by the NHHRC.

"Almost all agreed that the most equitable and efficient way to fund health care is through a universal health system funded through taxation" said Mr McBride. "In this way we all provide health insurance for each other. The policy of subsidising private health insurance is folly. There is strong evidence, including from the Australian Government Treasury, that this is poor policy. It should be abolished. Similarly the Commission's proposed use of private health insurance companies for some of its funding options was also seen as inefficient, inequitable and overly complex for consumers."

Mr McBride said AHCRA is more supportive of a regional model with all government funding distributed on the basis of demonstrated need, so that sicker and more remote areas would get more funding per head.

The two-day Summit was addressed by the Chair of the NHHRC, Dr Christine Bennett, and by the Minister for Health, Nicola Roxon.

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Key positions at the Summit were:

1. A single health system run by a 'national health commission' (Commonwealth-run preferably or alternatively a Commonwealth and state joint arrangement) that would develop a national clinical services plan and policy, and distribute funding from one pool of money, including current MBS (Medicare), PBS (medications) funding, and the PHI rebate. This would fund all public health services including general practice.

2. The funding and governance of all health services requires national leadership and local flexibility. So the NHHRC Option B had strongest support, i.e. for establishment of regional health authorities with funding allocated on basis of demonstrated need (so sicker or more remote areas would get more). A population size of approx. 100,000 to 500,000 would allow local responsiveness, but have a critical population mass to support primary and secondary services.

3. The 'national health commission' to be responsible for setting national standards and benchmarks for health outcomes.

4. Crucially the Summit reinforced the principle that health care resources should be raised principally from taxation, and for those funds to be distributed equitably to ensure the distributive benefits of universally accessible health care. Many delegates questioned the efficiency of building roles for private health funds when the evidence showed they were clearly much more expensive to run.

5. The Summit was concerned about the issue of equity, and supported some Commission proposals but felt others did not address issues of equity.

6. Delegates agreed the system should be driven by population /consumer/community needs, not by those of providers.

7. Unanimous support for multidisciplinary primary health care services delivering integrated primary health care, with majority support for a smaller role for fee-for-service payments.

8. The focus on significantly improving oral health services was seen as essential and welcomed although the proposed model needed amendment. Oral health funding should be integrated into the single pool.

9. There was strong support for more consumer-centred care and more consumer and community influence in individuals' own care, in quality improvement, and in broader health planning and priority setting. The Commission's proposals were welcomed but needed considerable strengthening, both for all services but also importantly in Indigenous health. Hence the expansion of the model of Aboriginal Community Controlled Health Services was supported.

10. There was strong support among AHCRA members for an Indigenous primary health care authority as a statutory body as proposed, as long as it was Indigenous-controlled. Investments in Indigenous health and capacity building were seen as vital, but the NHHRC report currently was seen as lacking a long term plan for achieving Indigenous health equity.

11. The Summit recognised that the effect of the social determinants of health (e.g. access to secure housing, education, a clean environment, water, personal security) on health outcomes was crucial and should be a priority in public policy planning. The Summit did not think the Commission addressed this sufficiently.

There was vigorous debate around all issues although consensus was not reached on every recommendation.