Address to the 'Improving the Australian Health Agreements' Workshop
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Australian Health Care Reform Alliance's perspective of the AHCAs

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The AHCAs have been primarily a financial instrument; that much we understand and accept. What I think is not acceptable to this Alliance is that the policy framework that should exist around this agreement does not. The requirements for reporting outcomes are too few; the obligations to deliver safe, high quality services are ineffective; and the siloed funding of hospitals services, as distinct from community care, aged care, primary health care, only add to poor coordination of care.

This fragmentation comes about because of circumstances such as the movement of people from a (federally funded) general practice to a (state/territory funded) hospital, they are moving in a separate "system". Or when (state/territory funded) emergency departments are overrun by people who are unable to get an appointment to see a (federally funded) GP. Or when elderly people, unable to access a (federally funded) aged care bed, are forced to languish in a (far more expensive, but state/territory funded) hospital bed, or between private and public services.

The fragmentation across the Commonwealth and the states is also manifest in the lack of an overall policy framework, which results in serious anomalies where people simply cannot get the services they need: in dental care; access to primary health care for Indigenous people; health services in the bush; and allied health services like psychology, physiotherapy, podiatry etc.

This travelling between systems, or as it has been more appropriately described, the "series of disconnected programs" that is our health system, means that very often vital information and records of people's care do not travel with them.

The lack of coordination and failure to transfer vital information not only risks the safety and quality of care to individuals, but it also costs money when tests and investigations are repeated, medications reordered, and so on. It is also means that no single provider clearly takes responsibility for the patient – leading to poor continuity of care and money and resources being wasted.

We need to acknowledge that the AHCAs are one part of a larger whole and indeed that the health reform agenda is part of a larger set of reforms associated with the National Reform Agenda and Commonwealth/State relations. This is about the role of health in the nation's future productivity and the participation of everyone in the social and economic life of the community.

The Rudd Government is interested in outcomes and health outcomes are determined by factors beyond the health system – housing, clean water, employment, nutritious food, and structural disadvantage. The health reform agenda needs to engage with this wider agenda if population health outcomes are to be achieved.

Broadening the Australian Health Care Agreements to cover services beyond hospital care could assist (but not solve) some of the problems with poor coordination and fragmentation.

AHCRA supports the government's proposal that in the short term the agreements be expanded to cover services beyond those of public hospitals. AHCRA supports this direction but it must also include provisions to ensure equitable access to all services when and where they are needed. As well as improving the integration of primary health/community based care with hospital care, the inclusion in the AHCAs of the current federal and state/territory funding for community-based care and public health measures would assist in the preventive measures we know can assist in reducing acute demand in the acute hospital sector.

The other subject of today is around how do we improve the accountability and transparency associated with expenditure and delivery of services under these agreements?

Recognising that there is a broader reform agenda currently in train in Australia, the opportunities for improving the Australian Health Care Agreements in the next round is possibly quite different to that which might emerge following recommendations for long term reform from the National Health and Hospital Reform Commission in relation to these agreements.

In an ideal world, the next round of AHCAs would be signed following the work of the Commission following the development of a long term health reform plan. However, we are not starting the process of reform from a blank slate. Hospitals must continue to deliver services and thus they must be funded to do so. (Perhaps the term of those agreements should be shorter however in order to align those agreements with the broader reform agenda).

However, improving the next round of agreements while the process of developing options for long term reform is undertaken is important. If we can't have what we want right now, let's at least get it as close to improved as possible.

The current situation is that the performance of public hospitals is currently largely based on *outputs* (actual services delivered) as opposed to *outcomes* (the impact of the services on an individual or group).[2]

The prime outcome of health intervention should be better health outcomes at both an individual and population level. What tools can be used to measure these?

AHCRA's principle focus of advocacy has been around the areas of rural health, workforce, Indigenous health, consumer engagement, quality and safety, equity, access, and efficiency.

The introduction of additional indicators to demonstrate measurements of health outcomes, and indicators that ensure that processes for the delivery of those services can also be monitored. This would help ensure the shortfalls that exist could at the very least be monitored; with the aim of course being improved performance.

For example, in the case of rural health, I think we need a system to ensure that people in rural and remote areas have access to funds proportional to their numbers; they have been missing out, and it is time we put a framework around making sure that doesn't happen.

With regard to workforce, there must be an obligation on hospitals for safe staffing. We know from the Royal North Shore most recently, but there are countless other examples, hospitals are not always staffed safely. The introduction of additional indicators for staffing, skill mix and workload are warranted. To use the example of nurses, there are strong arguments for the inclusion of such indicators. The effect of nursing interventions on the safety and quality of health care is now well documented, with significant relationships between nursing workload, nurse staffing, and nurse education and the avoidance of adverse patient outcomes, such as urinary tract infections, pressure ulcers, pneumonia, deep vein thrombosis, falls, postoperative wound infections, medication errors, upper gastrointestinal bleeds, sepsis, and death.

There are also significant relationships between nurse staffing, nursing workload, and nurses' work environment and the wellbeing of nurses themselves: identified over and over again as stress, burnout, occupational injuries, and ultimately, a loss to the profession, when nurses leave the profession.

Every nurse that leaves represents a loss of public funds, and treating nurses who are rendered ill or injured from their work is a financial cost to taxpayers too. There are significant on-costs for the community of nurses leaving nursing, as the education of every nurse is undertaken with public dollars, and each exit from the profession worth a loss of around $AUS150,000.

The allied health and medical workforces face similar challenges. The same energy must be given the development of indicators to address staffing, workload, safe working hours, and appropriate skill mix for doctors and allied health professionals working in our public hospital system.

Given the huge inflationary pressures faced by the health sector, we need to know that the care being provided is cost effective, so evaluation and reporting of services and associated outcomes are important.

Access to services in highly variable depending on geography and socioeconomic circumstances; we must ensure that performance indicators that can demonstrate the availability of services to people when they need them is extended beyond the very crude measure of waiting times.

The health of Indigenous people requires specific indicators; both in relation to the specific health outcomes, but also in the area of culturally appropriate care.

If community care were to be added to the AHCAs, then appropriate indicators should also be applied.

We know that serious problems exist with safety and quality of care. These agreements currently lack the sophisticated risk management plans that should be expected give the quantum of money they involve. Improving quality is urgent; therefore improved performance must be demonstrated through a range of safety and quality indicators within comprehensive risk management plans.

More work needs to be done to develop measures for performance on implementation of a nationally consistent electronic health record to improve integration and coordination of care.

When we consider the science around climate change it seems incongruous that hospitals as theoretically “health institutions” should be contributing to climate change and thus poorer population health outcomes. Some requirements around improving the greenhouse footprint of the health sector are warranted.

These are some of the ways we can improve the quality, integration, safety and quality, and effectiveness of care within the Australian Health Care Agreements that could be implemented in the next round of agreements. But more work needs to be done, in particular (and this extends beyond the AHCA) in determining how improvements to access and affordability can be addressed.

However, beyond the AHCAs there is a much larger reform agenda possible.

But this will need the development of a considerably strengthened framework of cooperation that has existed between our governments over recent decades. If I can stray out of the area of health reform for a moment to say that to deliver sustainable health reform, it may be that we first need constitutional reform. In order to overcome those challenges that have plagued health it may be necessary to start beyond health, at the COAG level perhaps, for we need a framework for cooperation that will extend beyond the current players. We cannot allow health to become hostage to the acrimonious political environment that has characterised federal/state relations in our recent past.

I will address these comments to the Minister’s Chief of Staff and Commissioner Gallop, when I say that I urge you to seriously and carefully consider, give the nature of this Alliance, the recommendations for reform from this group. As a broad alliance of health professionals, consumers, institutional service providers, researchers and academics, AHCRA is a microcosm of the sector, and the community, or for the politically motivated, the electorate, representing the people who work within the sector and most importantly all, those who use its services.

This makes us an ideal group for government and the Commission in “road testing” new policy ideas.

So we urge the Commission and the government to, when you turn you minds to the important task of long term health reform, that you consider these ideas from AHCRA. In developing a series of options or a proposed blueprint for reform, we encourage you to first consider what we want this new health system to look like.

It is vital that you start, not with the funding mechanisms, but with an understanding of what health services we need; only then can we begin the process of determining what services will best met those needs; and then design the mechanisms for funding, delivering and evaluating those services.

I say “we “in the spirit of cooperation with government and the commission; none of this can be done in a vacuum.

The process of determining those needs must necessarily start with a process of community engagement; a dialogue and consultation with the Australian people about the kind of health system they need and want.

Then must come the development of a national health policy which outlines the principles on which our health system is to be based and the broad strategies to achieve them.

Within this must necessarily be a primary health care policy; with preventive health strategies; and other national health policies: for rural health; mental health; child and infant health; Indigenous health and so on.

Once we know what system we want, what services we need and how we want to deliver them, only then can we design a funding system that will best facilitate that.

One of the fundamental principles of this system must be the provision of universal publicly funded services available to people on the basis of need, not their ability to pay.

Given that the Prime Minister has given as assurance of a root-and-branch review of the health system and evidence based policy, we urge both the government and the Commission not to shy away from a review of the policy of using public funds to subsidise private health insurance.

We are very pleased to have the Commissioner and so many of you here generating good ideas. This process must continue and I encourage members of AHCRA to continue to contribute your ideas to the executive; I invite non-members to consider joining AHCRA to support and influence this work; and for the Minister’s office, the department, and the Commission to work with us to achieve the aim of a fairer, safer, more efficient and more equitable, health system.