Australian Health Care Reform Alliance

# Analysis of National Health Reform to-date against AHCRA's key principles for reform

**February 2013**

## The Australian Health Care Reform Alliance

The Australian Health Care Reform Alliance (AHCRA) is a coalition of about 30 peak health groups working towards a better health system for Australia's future. We believe that all Australians are entitled to high quality and accessible health care, regardless of their level of income, geographic location or linguistic and cultural background. A list of AHCRA members is attached at Appendix 1.

More information about AHCRA can be found at www.healthreform.org.au

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**Analysis of National Health Reform to-date**

## 1. Introduction

This is a shortened and updated version of the presentation by AHCRA Chair, Tony McBride, at the 6th AHCRA Health Reform Summit, the Long and Winding Road, in August 2012. It includes a very broad analysis of the Government's 27 claimed reforms up to that point as well as the subsequent oral health announcement in late August). It covers a reminder about the key flaws and gaps in the system pre-reform, AHCRA's key principles for change, and an analysis of each reform against AHCRA criteria for effective change.

## 2. The Departure Point: a review of the key issues

Some of the signs that our health system was not performing optimally were:

- An irrational split of responsibilities between different levels of government and perpetual episodes of the Blame Game about who was meant to do what
- Inequities in the health outcomes between different groups in the community, in particular the continuing poor health status of Indigenous Australians
- The problems in accessing quality care experienced by many groups in the community, including people who are socio-economically disadvantaged and people living in rural areas
- High rates of preventable illness and diseases and increasing rates of avoidable hospital admissions
- Gaps in the provision of care in specific areas, for example dental services and mental health, and care for vulnerable groups, e.g. people with intellectual disabilities
- Poor coordination of care between health sectors, particularly impacting upon people with chronic and complex illnesses
- The large number of medical errors and adverse events that occur in the process of delivering care
- Workforce shortages across the spectrum of the health system and rigid professional structures.

## 3. Our compass: AHCRA's vision for health system reform

One of AHCRA's earliest tasks was to create a common vision and a set of principles for our future health system. It is worth remembering that these vision and principles were created by a coming together of consumers and health professionals and service organisations – so not an interest-based perspective. Although this does not make it unique, it does qualify as rare in the health cauldron and therefore has some special value.

AHCRA's vision is for

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

For AHCRA, the system's underlying principles should be based on:

- **Equitable access:** care available on the basis of need, not the ability to pay, and in a timely manner.
- **Equitable outcomes:** service orientation, resource allocation and attention to social determinants focused on outcomes, not inputs. This will mean ensuring those with special needs (including people with disabilities and those whose access to healthcare is restricted by cultural, linguistic or geographic factors) enjoy health outcomes equivalent to that of the general community.
- **Primary Health Care:** highly team-based, at centre of overall system, with strong preventive and early diagnosis / treatment focus.
- **Community engagement and consumer participation:** systems built as a partnership between services and consumers, carers and the Australia community more broadly. That is, consumer-centred care and strong consumer and community participation to ensure health services are designed and operated to meet consumer-defined needs.
- **Workforce:** At least self-sufficiency in training and retaining an appropriate and flexible health workforce to meet changing consumer and community needs.
- **Efficiency:** Health care based on the best available evidence and delivered by (teams of) the most appropriately skilled health professionals, and the responsibilities between governments and others for planning and funding the system should be very clear, based on effectiveness not history.

## 4. Criteria for analysis of reform to-date

Six key criteria were chosen for this analysis, developed from AHCRA's key principles. Thus we wished to assess whether each new policy and funding mechanism/initiative would:

- create positive permanent changes to what health care was provided (not just more of same)
- increase effective preventive effort / early intervention and better integrated multi-disciplinary primary health care
- improve equitable access to health care, especially primary health care
- ensure stronger consumer, carer and community engagement in both care and planning
- increase efficiency of use of resources and workforce
- create a more rational split of responsibilities between governments.

In applying these criteria to the 27 initiatives (see below), we including an assessment of whether the initiatives could be classified as 'reform'. This is not necessarily an easy question to answer, but in summary, we used the following definitions:

| Changes are reform if they: | Changes are NOT reform if they: |
|---|---|

| | |
|---|---|
| Are significant and permanent changes to what or how health care is provided | Are minor changes or short-term funding of existing approaches |
| Shift the focus towards prevention or early intervention (and hence reduce acute demand) | Just provide more treatment of already developed disease |
| Address inequities of timely access and outcomes across the country, including for marginalised groups | Reinforce status quo, i.e. do not address inequities between populations or states |
| Foster consumer-centred care and consumer/community engagement | Consider consumers as merely recipients of services |
| Offer more efficient care, e.g enable more people to receive care with equal or better outcomes, utilise more effective workforce arrangements etc | Offer more of the same when more efficient options are available |
| Clarify governmental responsibilities for health policy or funding | Continue or encourage state/territory based differences in approach, based on history not good practice |

## 5. Where have we been so far on our journey: progress to-date

Table 1 below is a quick summary of our assessment of the degree to which each of these criteria has been for each of the government's major initiatives, as outlined in their report 'National Health Reform: progress and delivery, September 2011', and updated with August 2012 dental spending. The report outlines spending on the reforms over five years.

The analysis is broad-brush, aimed at giving AHCRA an overall impression of progress (see Table 2) rather than a detailed assessment.

The ratings given have been:

- YES: criteria satisfied to a reasonable degree
- PERHAPS: criteria satisfied to some lesser degree or the potential exists for it to be satisfied
- NO: criteria not satisfied to any reasonable degree.

**Table 1: Assessment of AHCRA criteria for health reform vs. Federal Government 'national health reform' actions**

| **Hospitals: $3,434m over 5 years** | **Significant and permanent** | **Increase effective prevention /early intervention** | **Address inequities** | **Stronger consumer / community partnership** | **More efficient** | **Clarify responsibilities** |
|---|---|---|---|---|---|---|
| **Activity based funding (Casemix) and Independent Hospital Pricing Authority** | **YES** in most states- successful in Victoria although questions where not so well-developed sub-acute or community services | **NO** Rewards admission, not EI or prevention | **PERHAPS** Could increase access overall and hence those dependent on public hospitals, altho' risk it could reduce equity for some groups, e.g. people with intellectual disabilities. | | **YES** Drives more efficient care and innovation | **NO** |
| **Agreed formula for Commonwealth funding (45% - 50% of growth funding)** | **YES** | **NO** As above | **PERHAPS** As above | | **NO** | **PERHAPS** Minor impact as C/wealth will never become majority funder |
| **1316 more sub-acute beds (or equivalents)** | **PERHAPS** Enables quicker / more appropriate discharge and care but does not meet total demand. | **PERHAPS** Doesn't stop disease but enables quicker rehabilitation | **YES** addresses gap and inequity to some extent, given public hospital population | | **YES** Facilitates more appropriate care and better use of acute facilities | **NO** Does it muddy waters? |

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|---|---|---|---|---|---|---|
| **Targets for surgery, ED care etc** | **YES** Altho' may only shift hospital focus from meeting other indicators, given capped budgets. | **NO** Except to extent it provides quicker treatment for some | **NO** Except to extent it services public hospital population | **NO** But importantly success will require strong consumer overview | **PERHAPS** May drive innovation or divert focus | **NO** |
| | **Significant and permanent** | **Increase effective prevention / early intervention** | **Address inequities** | **Stronger consumer/ community partnership** | **More efficient** | **Clarify responsibilities** |
| **Local Hospital Networks (LHNs)** | **YES** | **NO** Except where LHN chooses to do so | **NO** Except where LHN chooses to do so | **PERHAPS** Some cases of LHNs increasing consumer participation | **PERHAPS** Improves local control and local innovation but risk of capture by minority interests | **YES** |
| **Eg MyHospital site ongoing** | **YES** | **NO** | **PERHAPS** Makes inequities/ gaps more transparent | **YES** Theoretically altho' tends not to shift consumer behaviour | **PERHAPS** Experience shows such data drives service improvement | **NO** |
| **Others** | | | Inequitable and inefficient out-of-pocket costs not addressed | | | |

| **Primary health care: $1,138 over 5 yrs** | **Significant and permanent** | **Increase effective prevention / early intervention** | **Address inequities** | **Stronger consumer/ community partnership** | **More efficient** | **Clarify responsibilities** |
|---|---|---|---|---|---|---|
| Medicare Locals (MLs): 61 around Australia * | **YES** | **PERHAPS** Some potential at local level but will need framework for collaboration with States and ANPHA | **YES** Creates organisations with service improvement mandate. Pop health planning role should expose inequities. Action reliant on each ML to prioritise though. | **PERHAPS** Some MLs are taking consumer and community engagement more seriously but not required | **PERHAPS** Has potential to drive local efficiencies or alternatively to create more inefficiencies, eg risk in after hours provision | **PERHAPS** Gives C/ wealth stronger role in all primary health care sector |
| Increased after hours services inc. GP HelpLine | **YES** | **PERHAPS** Not clear if net gain or loss yet | **PERHAPS** Could vary area to area depending on GP responses. Helpline valuable | **NO** | **PERHAPS** Unclear. Would be more efficient if it reduced unnecessary hospital visits but there is no evidence that this will occur. | **NO** Continues C/wealth role |
| 64 Super Clinics | **YES** | **PERHAPS** Theoretically but not inherently in many cases | **PERHAPS** In some cases SCs in high-need areas but not all. Infrastructure but not requiring integrated approach. Wasted opportunity. | **NO** Not required | **NO** Opportunity wasted | **PERHAPS** Strengthens Commonwealth role in PHC but considerable overlap with States still exists. |

| | |
|---|---|
| Other? | • Key risk that States will walk away from primary health care provision, and without sufficient Commonwealth funding/ engagement, there will be net reduction.<br>• Fee-for -service still major barrier to effective, equitable care, and inequitable and inefficient out-of-pocket costs not addressed<br>• Heavy-handed red-tape and bureaucracy associated with the reform measures might outweigh their benefit<br>• Insufficient funding for change management/transition<br>• Inadequate focus on outcomes rather than transactions<br>• Still lack of recognition of differences in service delivery requirements in rural/remote areas<br>• Insufficient addressing of mal-distribution of workforce (although some improvements in rural Australia)<br>• No attention to continuing focus on episodic care rather than consumers' treatment journey |

| **Aged care: $570m over 5 years** | **Significant and permanent** | **Increase effective prevention / early intervention** | **Address inequities** | **Stronger consumer/ community partnership** | **More efficient** | **Clarify responsibilities** |
|---|---|---|---|---|---|---|
| **Commonwealth takes full responsibility for aged care (except HACC in Victoria and WA)** | **YES** | **PERHAPS** Indirectly could create incentive for C/wealth to improve effectiveness PHC system. But silos may be barrier and HACC needs improving in many states. | | | **PERHAPS** Indirectly - incentive to improve efficiency of hospital system | **YES** |
| **Flexible $ to MLs for primary health care for older people** | **YES** Permanent but small scale. Is it cemented in enough to be called 'reform'?. | **PERHAPS** Potential but not necessarily. Recognises need to build links with community services | **YES** Potential | **NO** | **PERHAPS** Potentialto improve efficiency through supporting better transitions to/from acute care. | **YES** To some extent, increase C/ wealth role |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Consumer directed care packages** | **YES** Will take time to build up numbers so system responds innovatively | **NO** High level care only | **PERHAPS** Reconfigures to create better continuum of care. But unclear how HACC fits in | **YES** Gives power to consumer to direct care. Excellent initiative | **NO** | **NO** |

| **Mental Health: $1,349m over 5 yrs** | **Significant and permanent** | **Increase effective prevention / early intervention** | **Address inequities** | **Stronger consumer/ community partnership** | **More efficient** | **Clarify responsibilities** |
|---|---|---|---|---|---|---|
| **More headspaces and new EPPICs** | **YES** Need good evaluation to ensure effective | **YES** Increased early intervention, primary health care | **YES** Permanent reform: valuable piece of the jigsaw | **NO** | **YES** More appropriate care | **NO** Increases C/wealth role but divisions unclear |
| **Increased community-based and coordinated care, inc ATAPS and $ for Aboriginal services** | **YES** Permanent. Reform? Valuable? Confuses roles. | **YES** Prevention of relapse | **YES** Improves this somewhat | **NO** | **YES** Uses range of practitioners in more coordinated way | **NO** Increases C/wealth role but divisions unclear |
| **Ten Year Roadmap, new National MH Commission, new consumer peak** | **YES** New bodies. | | | **YES** Esp new consumer peak and consumer participation in Commission | **PERHAPS** Stronger guidance towards more effective care | **YES** Roadmap aimed at mapping implementation and clarifying roles |
| **Others, eg increase in MH Nurse Program, more counselling, suicide prevention** | **YES** Not reform but growing existing (valuable) activities | **YES** More preventive and early intervention activity | **PERHAPS** Not necessarily although if well-targeted they could promote better mental health among disadvantaged groups. | **NO** | **PERHAPS** | **NO** Increases C/wealth role but divisions unclear |
| **NEGATIVES** | • Limitations on scope of Better Access Mental Health Program (minus $580m)<br>• although current scheme not very equitable<br>• So debate about impact of this measure | | | | | |

| **Dental: $541m over 4 years plus $4b over 6 years** | **Significant and permanent** | **Increase effective prevention / early intervention** | **Address inequities** | **Stronger consumer/ community partnership** | **More efficient** | **Clarify responsibilities** |
|---|---|---|---|---|---|---|
| **$2.7 billion funding for entitlement to subsidised basic dental treatment for 66% of Australian children** | **YES** Highly significant | **YES** Will make more likely that highest need children get regular screening and care | **YES** Aimed squarely at two-thirds of lowest income children | **NO** | **YES** More effective and equitable than the Teen Dental Plan it replaces | **PERHAPS** Commonwealth assumes responsibility for funding most children's oral health but States have to keep up investment. Still no C/ wealth commitment to universal scheme |
| **$1.3 billion for around 1.4 million additional services for adults on low incomes** | **YES** Highly significant | **PERHAPS** Will make more likely that highest need adults get regular screening and care but not aimed at prevention | **YES** Aimed squarely at lowest income adults | **NO** | **YES** More effective and equitable than the Chronic Disease Dental Scheme it replaces | **NO** States and Commonwealth share responsibility and funding |

| | Significant and permanent | Increase effective prevention / early intervention | Address inequities | Stronger consumer/ community partnership | More efficient | Clarify responsibilities |
|---|---|---|---|---|---|---|
| **Scrapping of Medicare Teen Dental Plan (TDP) and the Chronic Disease Dental Scheme (CDDS)** | **YES** Significant | **PERHAPS** Overall new funding is more rational and likely to be effective. However whilst many consumers will benefit from new, some with chronic diseases who are not on low incomes will receive less on this new scheme. | **YES** Much better targeted and makes government subsidy more equitable | | **YES** More effective for teens – TDP was only screening, not care and so of limited value. | **PERHAPS** Only to extent that new funding achieves this |
| **Workforce measures to rural/ outer metro and to more (various) OH profs** | **YES** | **NO** | **YES** Especially in rural areas | | **YES** Broaden range of oral health practitioners | **NO** |
| **Prevention/ oral health promotion** | **YES** | **YES** | **YES** Prevention focussed on most disadvantaged populations | **NO** Although might be by-product | **YES** Reducing demand for dental care | **NO** |

| **Prevention: $1,824m over six years** | **Significant and permanent** | **Increase effective prevention / early intervention** | **Address inequities** | **Stronger consumer/ community partnership** | **More efficient** | **Clarify responsibilities** |
|---|---|---|---|---|---|---|
| **National Preventive Health Agreement $872 over 6 years** | **YES** | **YES** In collaboration with States and local govt | **PERHAPS** As the agreement targets risky behaviours more common among disadvantaged groups | **NO** | **NO** | **YES** |
| **Establishment of ANPHA – $952m over 5 years** | **YES** | **YES** Valuable in coordinating effort | **PERHAPS** If successful in reducing risky behaviours in disadvantaged groups relative to the general population. | **NO** | **NO** | **NO** Creates stronger C/ wealth role but States still significant |

| **e-health: $1,087m over 5 years** | **Significant and permanent** | **Increase effective prevention / early intervention** | **Address inequities** | **Stronger consumer/ community partnership** | **More efficient** | **Clarify responsibilities** |
|---|---|---|---|---|---|---|
| Person-controlled electronic health record | **YES** | **PERHAPS** Potential to improve prevention/ early intervention at individual level? | **NO** | **YES** At individual consumer level, gives more control over information | **YES** Reduces multiple record taking, reduces medication errors etc | **YES** Significant step at service level |
| Telehealth | **YES** | **PERHAPS** If it increases access to preventive/ early intervention services. | **PERHAPS** Increases access esp for rural consumers | **NO** | **YES** Uses workforce better | |

| **Workforce: $1,788m over 5 years** | **Significant and permanent** | **Increase effective prevention / early intervention** | **Address inequities** | **Stronger consumer/ community partnership** | **More efficient** | **Clarify responsibilities** |
|---|---|---|---|---|---|---|
| More GPs and other allied health training places, more specialists, bias towards rural and remote Australia | **YES** | | **YES** Will assist esp in rural & remote. However, need broad support to ensure retention. | | **YES** Esp broadening of roles | **YES** Increases C/wealth responsibility for workforce |
| Health Workforce Agency | **YES** | | **PERHAPS** If can plan to increase rural workforce | | **YES** Possibilities to encourage more rational and flexible use of workforce | **YES** Creates planning where little before |

Adding up these rough assessments, Table 2 gives us the following.

**Table 2: Totals of assessments**

| TOTAL | Significant and permanent | Increase effective prevention /early interventio n | Address inequities | Stronger consumer & community partnership | More efficient | Clarify government respons-ibilities |
|---|---|---|---|---|---|---|
| **% YES** | **96%** | **29%** | **44%** | **21%** | **49%** | **31%** |
| Total YES | 26 | 7 | 11 | 4 | 13 | 8 |
| Total PERHAPS | 1 | 10 | 11 | 2 | 9 | 5 |
| Total NO | 0 | 7 | 3 | 13 | 5 | 13 |
| Total applicable | 27 | 24 | 25 | 19 | 27 | 26 |

**SO WHAT? Against our key criteria, what has been achieved?**

Whilst the analysis above reflects our broad-brush assessment of each initiative, the totals in the last table only provide a very rough and ready shorthand summary of progress. However, noting this qualification, the table does indicate that:

- Most of the initiatives are permanent (as much as one can say) in nature (e.g. not short-term funding, or trials)
- Less than a third are aimed at increasing a focus on prevention or early intervention
- Less than a half are aimed at addressing inequities
- Few address increasing the involvement or centrality of consumers or community in the system
- About a half seem to be addressing efficiency
- About a third seek to clarify funding/policy/service delivery responsibilities
- Some key disadvantaged groups, especially those typically hidden such as people with an intellectual disability, are not identified as requiring specific strategies.
- Overall this amounts to a picture of disjointed incrementalism with some progress but a disappointing level of action on some of the most important issues to AHCRA members
- There is still a long way to go on the long and winding road.

**How do the changes address AHCRA's original list of system problems?**

Table 3 gives a brief summary comment on the progress made by the above 27 reforms in addressing the originally identified flaws in the system (see above).

**Table 3: Degree of progress addressing original flaws.**

| | |
|---|---|
| **Blame Game** | Some modest progress |
| **Inequitable health outcomes** | Some little progress, much indirect |
| **Inequitable access** | Little progress |
| **High preventable illness / avoidable admissions** | Little progress although ANPHA establishment a positive move. The social determinants of health have not been substantially addressed in the reform agenda, although the tobacco plain packaging initiative was a very significant gain. |
| **Gaps, e.g. dental and mental health** | Good start in addressing mental health. Welcome initiatives in oral health, although still modest in relation to need. Can provide building blocks for future universal system. |
| **Inadequate care for vulnerable groups** | Little progress, mostly indirect. Some specific groups, such as people with an intellectual disability, completely ignored. More responsibility for care is falling on family /carers/volunteers. |
| **Poor coordination between sectors** | Little progress |
| **Stronger consumer participation in care and system** | Little progress. No enabling framework for consumer participation. |
| **Medical errors / adverse events** | Not addressed although falls into work of ACSQHC |
| **Workforce issues** | Range of initiatives, increase in training numbers, rural incentive programs, increase in flexibility of workforce |

## 6. Conclusion

Overall, the reforms appear to be moving in some of the right directions although overall modest in nature and patchy.

Positives of the reform process and other Federal Government initiatives in the last three years include:

- the recent national dental package, with its reform of at least child and adolescent system, is a significant gain, and creates some of the building blocks required for a future universal system
- Greater funding into innovative areas of mental health provision
- Establishment of Medicare Locals (MLs) as supports for and change agents for reform and improvement in primary health care. In particular their population health planning will create shared understandings of the local system (currently not available) and a platform to address the gaps identified. The MLs also offer new opportunities for community engagement.
- Other initiatives offer the opportunities for a more nationally consistent system, and one where the efficiencies gained in some states can be spread across the remainder (e.g. in hospital care pricing).
- And although not strictly part of the reform process, the Federal Government's legislation for tobacco plain packaging was a major gain.

However, for many initiatives there is too little implementation progress so far to measure what has been achieved. The vast majority of health consumers would have noticed little impact so far, so judgement on many reforms may have to wait a year or two to be valid. And for some, implementation will need to be closely monitored to ensure that the anticipated benefits are achieved.

However there are also a range of important gaps and system flaws that have not been adequately addressed or even recognised at all. So in some key areas there has been no or little progress, including prevention (whose share of the national health budget is going backwards[1]), consumer participation and moving towards consumer-focussed services, and action to meet the needs of some identified vulnerable population groups, including people with intellectual disabilities. The fee-for-service model remains unscathed despite its many drawbacks including constraining innovation. In the crucial arena of the Blame Game, the recent stoush over Victorian hospital funding shows it has remains as virulent and caustic and ever. In other areas there has been only very modest progress (e.g. in increasing the equity of the system so for example maldistribution of services and professionals remains chronic in many parts of Australia and out-of-pocket expenses for consumers continue to rise, hitting the poor hardest). There has also been some action in workforce, for example to improve the availability of allied health professionals in rural areas, but it falls far short of the need (and has been exacerbated by the wholesale slashing of allied posts by at least one State Government).

[1] Australian Institute of Health and Welfare 2012. Health expenditure Australia 2010-11. Health and welfare expenditure series no. 47. Cat. no. HWE 56. Canberra:

Two key challenges present themselves for AHCRA and its members. The first is to continue to advocate for the gaps to be addressed, albeit in an environment where the appetite of the major parties for significant reform appears sated. The second is to identify opportunities to influence the effective implementation of the current reform agenda, especially those addressing equity, the strengthening of prevention and primary health care and reducing demand on hospitals, so that such reforms achieve the maximum possible benefit to the community.

## Appendix 1: Current members of AHCRA

- Allied Health Professions Australia
- Audiology Australia
- Australian College of Nurse Practitioners
- Australian Council of Social Service
- Australian Federation of AIDS Organisations
- Australian Healthcare and Hospitals Association
- Australian Health Promotion Association
- Australian Nursing Federation
- Australian Rural Health Education Network
- Australian Women's Health Network
- Australian Wound Management Association
- Chiropractors' Association of Australia
- Chronic Illness Alliance
- Continence Foundation of Australia
- Country Women's Association
- CRANAplus
- Doctors Reform Society
- Family Planning Victoria
- Health Care Consumers' Association (ACT)
- Health Consumers Network
- Health Consumers of Rural and Remote Australia
- Health Issues Centre
- National Council on Intellectual Disability
- National Rural Health Alliance
- Paramedics Australasia
- Public Health Association of Australia
- Public Hospitals, Health and Medicare Alliance, Queensland
- Royal College of Nursing Australia
- Services for Australian Rural and Remote Allied Health
- Tasmanian Medicare Action Group