



Revitalising Health Reform – Time to Act

Discussion Paper

September 2007

Who we are

The Australian Institute of Health Policy Studies (AIHPS) is a national institute devoted to studying the ways in which health policy can improve the health of all Australians

AIHPS is not based in a single institution, but rather, it harnesses the research capacity, policy and other expertise coming from a number of universities and other organisations from right around Australia, as well as many other health and non-health industry organisations from the government, non-government and private sectors.

AIHPS helps to set the agenda for health policy research and discussion in Australia. It aims to:

- *Stimulate and conduct policy-relevant health research in Australia*
- *Encourage debate about the needs of the health system*
- *Explore policy solutions to the issues and challenges facing the health system and the health of Australians.*

Suggested citation

Willcox S, Lin V, Watson R & Oldenburg B. (2007) Revitalising Health Reform - Time to Act. Melbourne: Australian Institute of Health Policy Studies.
ISBN 978-0-9804303-1-8

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Executive Summary – Time to Act on Health Reform

The Australian Institute of Health Policy Studies has commissioned this Discussion Paper to encourage broad community debate and, importantly, action on reform of Australia's health care system.

This report demonstrates that, all too often, existing processes for health system reform are ineffective. *It documents the 'unfinished business' on health system reform since 2000. For example:*

- *The Federal Parliament has undertaken three major inquiries into health funding and Medicare. But, many important and sensible recommendations from these inquiries have not been seriously examined by governments, let alone implemented:*
 - *For example, the Senate Inquiry into Public Hospital Funding recommended in 2000 that "Health Ministers give urgent consideration to the development of a national health policy, informed by community consultation". Seven years later, there is still no national framework that spells out for Australian citizens their rights under a universal health insurance system, the role of public and private health services, and a future vision of how health services should be organised and funded to improve health outcomes.*
 - *In 2006 the House of Representatives Inquiry into Health Funding recommended that consumers should have access to better information on how hospitals and individual doctors perform on quality and safety measures. This recommendation is hardly new, with numerous calls for 'health report cards' over many years, including following the deaths at Bundaberg Hospital. Yet, as of June 2007, only one state – Queensland – has commenced publishing information on the clinical quality of care provided at individual public hospitals. At a national level Health Ministers agreed in July 2004 to publish sentinel events data, but it took until July 2007 for the first national sentinel events report to be released. This recent report is still embryonic, with no information published at the level of individual states/territories or hospitals, and with no data included for private hospitals.*
- *The Productivity Commission has produced many reports on health-related issues, covering necessary reforms to the health workforce, medical technology and general practice. While most of these reports were specifically commissioned by government officials, there has been slow progress by governments in acting on the Productivity Commission's recommendations.*
 - *For example, the Productivity Commission recommended strengthening the assessment of medical services that are funded through the MBS through establishing an independent review committee to advise on the safety, effectiveness and cost-effectiveness of proposed changes. This recommendation – similar to existing arrangements for the review of pharmaceuticals – was not accepted by the Australian Government.*
- *Politicians and senior health bureaucrats regularly meet to discuss health reform, including through formal channels such as the Council of Australian Governments, the Australian Health Ministers' Conference and the Australian Health Ministers Advisory Council. But these processes are themselves in need of reform:*
 - *Current meetings focus on 'promises' or commitments to health system reform, but there is no mechanism to ensure that reform is actually delivered. Health Ministers and bureaucrats regularly endorse national strategies and service improvement frameworks, such as the National Chronic Disease Strategy. Many of these reports are aspirational, destined*

for filing on bookshelves or worse, because they lack new investment, implementation plans or any accountability mechanisms by which governments are required to report back on progress to consumers and health professionals on what has been achieved.

- Politics regularly intrudes on the timing and effectiveness of these meetings. Federal and state/territory elections or forthcoming negotiations of the Australian Health Care Agreement often limit discussion on important health issues. Health Ministers did not meet for nine months in the lead-up to the 2003 Australian Health Care Agreement negotiations, while State Premiers walked out of the Council of Australian Governments meeting in August 2003 in protest at the Commonwealth's funding offer for public hospitals. This environment is hardly conducive to effectively delivering important reforms to the Australian health care system.

Health system reform is imperative. There have been literally hundreds of reports in recent years that provide the evidence for why reform is needed. **The health system is under stress and many Australians are not achieving good health outcomes,** as shown by the following examples:

- Patients in rural areas experience higher levels of certain cancers and die more often from these cancers. Prostate cancer mortality is 21% higher for men living in rural and remote areas compared to men in capital cities.
- There are about 7000 cases of staph infections every year in Australia, with about 25-35% of people dying from these infections. Yet, there is no routine, national monitoring system that might improve prevention and control of these infections.
- Australians are paying a huge \$16.5 billion of health costs directly out of their own pockets – 19% of total health spending. The cost of accessing health services is a barrier to necessary care. A recent survey found that 29% of Australians reported failing to access medical care (such as visiting a GP or filling a prescription) over the past 12 months due to costs.

Opinion polls consistently show that consumers place a very high value on a well-functioning health system. In the most recent national poll, 79 per cent of Australians rated health and Medicare as very important in influencing their voting preference in the next federal election.

In addition, **this Discussion Paper reports on recent compelling evidence on the business case for health system reform,** including:

- Improving the productivity of how health services are delivered could result in savings of around \$3 billion. This would allow thousands more patients to be treated, with major scope for improvement in access, quality and effectiveness of health services, leading to better health outcomes.
- There is huge scope to improve the productivity and efficiency of health service delivery. For example, there is a 35 per cent difference in the average cost of treating patients in public hospitals between the most and least efficient of the states and territories.
- Doing the right thing to the right patient at the right time in the right setting would generate enormous savings of at least \$1 billion, as well as better outcomes for patients. For example, some older patients are inappropriately kept in public hospitals due to difficulties in getting access to community-based or residential care and support.

There are many good ideas and proposals to reform the Australian health system. The Australian Institute of Health Policy Studies, together with many health stakeholders, is urging governments to take action on four critical reform directions:

1. Create a health system focused on prevention, promotion and wellness
2. Strengthen the role of primary health care
3. Create a high-performing and publicly accountable health system
4. Ensure fair and equitable access to health services for all Australians (including Indigenous people, rural and remote populations, and other groups).

These are vitally important issues and many groups have developed detailed reform proposals under each of these reform directions. **But the challenge in health system reform is translating good ideas into concrete action.** A major stumbling block is that the 'machinery' or governance of health reform does not serve Australians well and is itself in need of reform. Health system reform discussions often occur behind 'closed door' meetings of health bureaucrats and politicians, with opportunities for meaningful engagement by health stakeholders limited and even less participation by individuals or broader communities of interest outside the health sector.

Accordingly, **the Australian Institute of Health Policy Studies is suggesting three 'reform pathways' that could be implemented to improve our capacity to achieve real progress on health reform.** These reform pathways are:

1. Embed the values and priorities of individual consumers into a strategic vision and national health reform agenda through engaging in a national consultation dialogue on what Australians want from their health system; and
2. Broaden participation in the development of health reform options through creating a broad community and business coalition to take a leadership role in shaping health reform options; and
3. Make governments more accountable for delivering real health reform through establishing an independent monitor to publicly report on progress in implementing agreed reforms to the health system.

These reform pathways could be implemented in many ways, but some preliminary suggestions to stimulate further debate are described.

The **first reform pathway of consumer engagement** could involve investment by governments in a national community and consumer consultation program on the values, principles and priorities that could shape the vision of our future health system. Similar national consumer engagement programs have occurred in the United Kingdom, New Zealand, Canada, France and Sweden, and there are many possible approaches including citizen juries, focus groups, consensus conferences and deliberative polling.

The **second reform pathway of broad participation in the development of health reform options** could be implemented through the **establishment of a new community and business leadership coalition to act as a spearhead in driving action on health reform.** Health reform is ultimately everyone's business, so proposals for change should be as broadly based as possible.

The **third reform pathway of greater accountability and monitoring on the progress of reform** could involve the creation of an independent body to monitor whether governments are delivering on their health reform commitments. For example, the Health Council of Canada was set up in 2003 to 'shine the light' on health system reform through providing annual progress reports on whether governments have achieved agreed health system reforms. An Australian independent monitor of health system reform progress could help ensure that commitments are turned into action, and that action results in real improvements in health outcomes.

1. Introduction

Health reform has new impetus.

The Council of Australian Governments agreed on a major health reform agenda in February 2006¹. Negotiations are shortly to commence on the next five-year public hospital funding agreements due for signing in June 2008. The Productivity Commission has delivered its assessment that improving the efficiency of the health sector could release savings of \$3 billion². It found that GDP could be boosted by up to 9 per cent through enhancing workforce participation and productivity.

Most health stakeholders agree that the system is ripe, indeed overdue, for reform now.

"2006 saw significant policy rejuvenation in the health arena – it is an unprecedented time for health reform." (Australian General Practice Network, October 2006)³

"Australia's health funding system has not changed significantly since the introduction of Medicare, over 20 years ago....The AHA believes our current system of funding and delivering health services is far from optimum if we want to achieve good value for money." (Australian Healthcare & Hospitals Association, August 2005)⁴

"Difficult though reform might be, taking no action, and finding our health system also at five minutes to midnight, is surely not an option. Reform is necessary, inevitable, and like addressing climate change, requires bold and visionary action." (Fiona Armstrong, Australian Health Care Reform Alliance, June 2007)⁵

But, some are sceptical about the political capacity and will to enact major reforms.

"The system is an imbroglio, a huge and tangled mess which imposes needless costs on the Australian community. That said, it is fairly obvious that the political vested interest in retaining a 'cost and blame' shifting system is so powerful, the inertia so large, that the AMA has no expectation of any meaningful reform of Commonwealth/State relations in health care." (Australian Medical Association, May 2005)⁶

And, others caution that participation in health reform is limited to an 'insider club', with leading health stakeholders themselves contributing to the problem of insufficient action on health reform.

"We also need to introduce countervailing power in the health sector. The debate about health resources currently only takes place between ministers and doctors. The community is excluded. The media savvy and influential are able to skew the spending of our scarce health dollars." (John Menadue, October 2006)⁷

The Australian Institute of Health Policy Studies commissioned Dr Sharon Willcox of Health Policy Solutions to prepare this report card on reform. It examines:

- WHY we need health reform – what a reformed health system would mean for the community in terms of better health outcomes, and the business case for reform including a healthier workforce and economy due to improvements in participation and productivity (Chapter 2);
- WHERE we have come from – what has been the progress in implementing health reform and importantly, what are the lessons and unfinished business in implementing health reform (Chapter 3);
- WHO is advocating for health reform – the leading proponents of reform, using principles to shape desirable health reforms, and current health reform proposals including targeted reform and governance/financing reform (Chapter 4); and
- WHAT needs to happen – next steps to take action on health reform (Chapter 5).

2. What is the rationale for reform of the health system?

2.1 The case for reform – better health outcomes

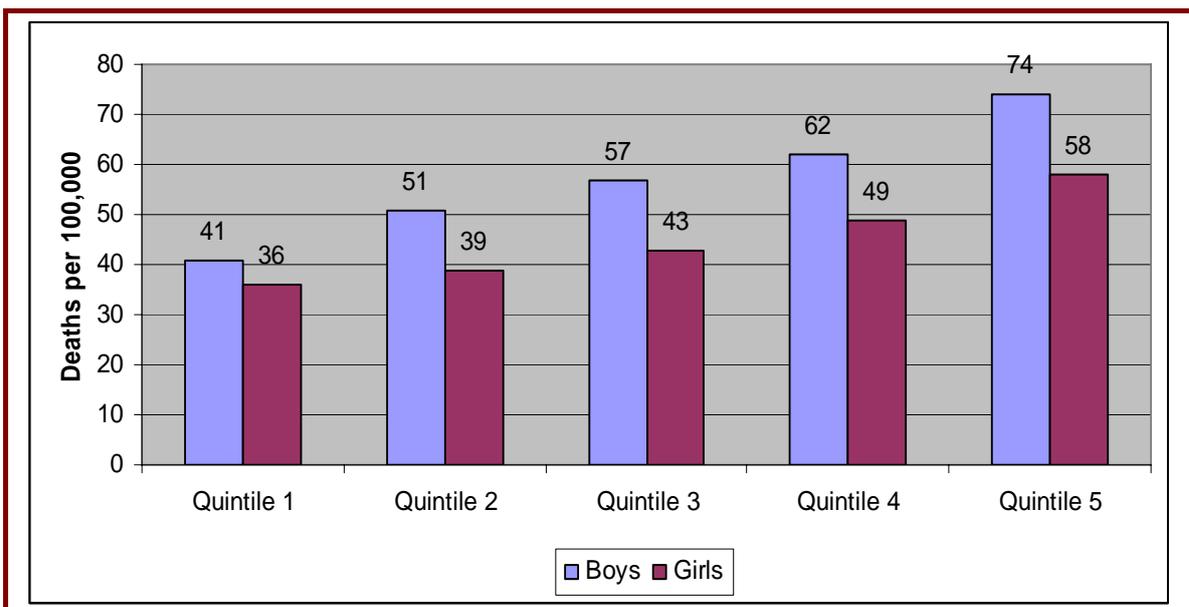
Numerous reports regularly document both the pressures facing our health care system and the consequences in terms of poor health outcomes for consumers.

The most recent Australian ‘burden of disease’ report identified that **there were more than 2.63 million years of healthy life lost in 2003 due to the burden of disease and injury**⁸. Many chronic health conditions share common risk factors that could be reduced if there was a greater focus on preventive health. For example, high body mass and physical inactivity together account for 60% of the burden of disease associated with type 2 diabetes, a largely preventable condition. But these two risk factors are also important contributors to cardiovascular disease and cancer - so that preventing risk factors pays potentially huge dividends in reducing the overall burden of chronic disease.

On equity grounds, **our health care system often fails to deliver the same access, quality of care and health outcomes for all Australians**. Recent reports have identified that:

- There are excess rates of prostate cancer mortality for men living in **rural and remote areas** of Australia (21% higher), compared to men living in capital cities⁹. This might be caused by differential access to prostate-specific-antigen (PSA) testing and follow-up with radical prostatectomy for early-stage disease. Other reasons might include differences in the management of men with advanced prostate cancer, due to less access to urologists and radiation oncology.
- Young children from the most **socio-economically disadvantaged areas** have significantly higher death rates. Figure 1 below shows that there is a 78% higher death rates for boys and a 62% higher death rate for girls living in the most disadvantaged areas. Many factors contribute to poorer health status among such children including higher smoking rates of mothers, lower uptake of immunisation, lower rates and duration of breast-feeding, and lower participation in quality pre-school education programs¹⁰.

Figure 1: Death Rates from All Causes, Australian Children (0-14) by Socio-Economic Disadvantage¹¹



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- **Indigenous populations** continue to experience extremely poor health outcomes. The incidence rate of end stage renal disease has increased by 120% between 1991 and 2004; Indigenous men aged between 35-54 have hospitalisation rates for injury and poisoning that are three to four times higher than other men; Indigenous infants die at much higher rates in their first year of life – the infant mortality rate is 12.2 per 1000 live births compared to 4.4 for non-Indigenous infants.¹²
 - The **cost of accessing health care services** continues to be a barrier for many people. In a 2004 survey, almost one in three Australians (29%) reported failing to access necessary medical care over the past 12 months (including visiting a GP, having a medical test or filling a prescription) due to costs.¹³ Despite universal public insurance and relatively high rates of private health insurance, individuals are shouldering a greater share of health spending through co-payments. In 2004-05 consumers directly met \$16.5 billion – equal to 19 per cent of total Australian health spending - up from 17 per cent met by individuals in 1994-95¹⁴.

On quality and safety grounds, **there is considerable scope for improvement with thousands of Australians harmed or dying each year** due to problems with how health services are organised and delivered. For example:

- There are an estimated 7,000 cases of **Staphylococcus aureus blood stream infections** each year in Australia, with median death rates of between 25-35% depending upon the strain of infection. About one-half of these infections occur in hospitals and about one-third are associated with community-based health care procedures such as dialysis and the use of catheters. More effective control and prevention is hindered by the lack of routine monitoring, unlike the United Kingdom which introduced mandatory reporting in 2003¹⁵.
- **Adverse events** are estimated to cost Australian hospitals about \$2 billion annually, with one in fifteen (or 7 per cent) of admitted patients experiencing an adverse event. Patients with an adverse event are likely to stay in hospital about 10 days longer than those without adverse events, and have a risk of dying in hospital seven times higher than patients without these complications¹⁶.
- **Better uptake and compliance with clinical guidelines** could help improve health status. For example, a comprehensive 2004 Australian study found that: about half of Australians with high blood pressure (a major risk factor for cardiovascular disease) remained untreated; between 65-80 per cent of people with asthma did not have a written asthma plan; and many strokes could be prevented by prescribing suitable medication for people with atrial fibrillation (irregular, rapid heart rhythms)¹⁷.

Consumers consistently rate health as the first or second most important issue influencing their voting preferences¹⁸. Over the past ten years opinion polls have indicated that health and Medicare is one of the top two issues, competing with unemployment in the late 1990s or education in this decade, as critical to federal election voting preferences. In the most recent national poll (February 2007), water planning (viewed by 82% as very important) edged out health and Medicare (79%) for the first time. However, a well-functioning health system is much more important to consumers than many of the issues currently dominating the media and political landscape – such as industrial relations (viewed as very important by only 48%), national security (60%) or the environment (70%). Clearly, consumers are experiencing many of the access and quality problems described above and want political action to ensure a better health system.

2.2 The case for reform – a healthier workforce and economy

The Productivity Commission recently made a compelling economic case for implementing health reform¹⁹. It was tasked by the Federal Treasury with assessing the economic and fiscal impacts of the National Reform Agenda agreed to by the Council of Australian Governments (COAG) in February 2006.

The National Reform Agenda comprises three streams: competition reform (focussing on energy, transport, infrastructure and planning, and climate change); regulatory reform; and human capital reform (comprising health, education and training, and work incentives). In turn, the health component of the National Reform Agenda comprises two distinct streams:

- Improving the delivery of health services including modifying health payment arrangements; and
- Improving workforce participation and productivity by reducing the incidence of illness, injury, disability and chronic disease in the community.

The Commission's 'headline' findings on the impact of implementing health reform were that:

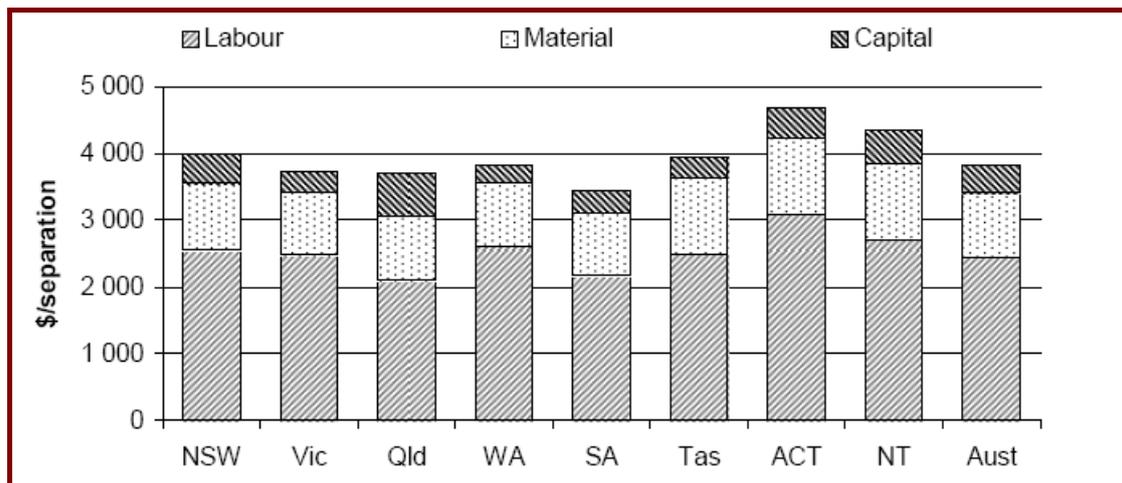
- **Improving the productivity of health service delivery by 5 per cent could produce savings of around \$3 billion;**
- These productivity savings would be equivalent to a potential increase of nearly \$4 billion in net revenues of Australian governments after 10 or more years; and
- **Boosting workforce participation through human capital reform (health, education and work incentives) could result in a 6 per cent increase in GDP after 25 or more years, while enhancing productivity could generate a further 3 per cent increase in GDP.**

In undertaking this modelling, the Productivity Commission drew on studies concerning the inefficiencies in the current health system, together with findings on the potential to unlock substantial economic growth through a healthier population. Some of the intermediate findings and assumptions used by the Productivity Commission include:

- **Productivity gaps (the difference in performance relative to observed best practice) in the Australian hospitals sector are likely to be in the order of 20-25 per cent.** An illustration of the significant efficiency variations is shown in Figure 2 that compares the cost of treating patients in public hospitals across Australia. There is a 35 per cent difference in the average cost of treating patients in public hospitals between the most efficient jurisdiction (South Australia at \$3,450 per patient) and the least efficient jurisdiction (the Australian Capital Territory at \$4,684 per patient).
- **Governments have more scope to improve productivity in public and private hospitals than in non-hospital health services (such as GP and specialist services).** The Productivity Commission's estimates of almost \$3 billion in savings due to improved health sector productivity are based on quite conservative assumptions about how much of the productivity gaps can be 'bridged' through National Reform Agenda type reforms. It assumes that:
 - Scope for productivity improvements in the hospital sector is linked to removing barriers to job redesign and addressing performance variability associated with complex operating systems and service characteristics of hospitals including their size, structure and location;
 - **One-fifth of the 20 per cent productivity gap in the hospital sector can be bridged, resulting in a 4 per cent gain in the hospital sector, equivalent to \$1.17 billion in savings;**

- There is less scope for productivity savings in medical services due to the 'intricate funding arrangements' of the Medicare Benefits Schedule.
- **One-tenth of the 20 per cent productivity gap in other health services can be bridged, resulting in a 2 per cent gain in the other health services sector, equivalent to \$634 million in savings.**
- **Further productivity savings of \$1.04 billion are achievable due to improving allocative efficiency through changes to the 'composition' of services across the health sector.** The Commission gives examples of what it means by compositional changes including:
 - Inappropriate use of hospital beds for older people due to shortages of residential care services;
 - Inappropriate use of hospital services that could be avoided through the provision of early intervention, prevention and disease management programs in the community; and
 - Inappropriate use of high-cost emergency departments to provide primary care services that should occur in the general practice setting.

Figure 2: Cost per patient in Australian public hospitals, 2004-05²⁰



In summary, the evidence for health reform is compelling – there is huge scope to improve quality, access and health outcomes for all Australians, while simultaneously achieving a healthier, more productive workforce and a stronger economy. Opinion polls consistently show that consumers place a very high value on a well-functioning health system.

3. What has been the progress to date in reforming the health system?

While there are many challenges and areas for improvement in the health system, **it would be incorrect to assume that health reform is a blank slate**. For those working in the health sector, it seems as if debate and action on health reform is continuous with many inquiries, reviews and changes to the organisation and financing of health services. The health sector is subjected to continuing reform and inquiry at many levels including through major government inquiries and reviews at a state or national level and the introduction of new programs and initiatives in the context of government budgets. Much health reform and innovation occurs directly at the level of hospitals or teams of clinicians, developing better ways to treat patients and prevent illness.

This section presents an overview of the progress on health sector reform over the past decade or so. Notwithstanding the challenges previously identified, it should be evident that **there is a solid track record of ongoing efforts and real achievements in health sector reform**. But, there is also considerable 'unfinished business', with many recommendations for change yet to be implemented or different levels of uptake of reform initiatives across jurisdictions or across sections of the health sector.

The following discussion is organised around the four dimensions of national reform, private health sector reform, reform of Commonwealth funded health services and reform of State funded health services. Although there is inevitably overlap across these somewhat arbitrary groupings, they have been chosen as **they illustrate the different opportunities, governance approaches and audiences for debate and action on health sector reform**.

3.1 Progress on national health sector reform

The national arena for debate on health sector reform deals with some of the most strongly contested and intractable issues including roles and responsibilities between governments for various health services and the appropriate level and composition of spending on health services. Achievement on health reform is generally slower at the national level due to both the complexity of the issues and the challenges associated with balancing views of multiple stakeholders.

Progress on health reform at the national level occurs through several different channels including parliamentary inquiries, reports of national organisations (such as the Productivity Commission), meetings of Commonwealth and State Health Ministers, and most recently, the Council of Australian Governments.

3.1.1 Parliamentary inquiries

Appendix 1 summarises the major recommendations of the three parliamentary inquiries into broad health issues since 2000. The Senate and the House of Representatives committees reviewed health funding arrangements in 2000 and 2006 respectively, while a 2003 Senate Select Committee examined the operation of Medicare.

Lessons and unfinished business

- Parliamentary inquiries are, by their nature, highly political and tend to produce partisan recommendations, rather than building consensus for agreed reform directions. **The big picture reforms recommended by these inquiries have largely not been adopted**. For example, unfinished business includes recommendations on:
 - Development of a national health agenda;
 - Establishment of a new National Health Reform Council to consult with the community on the future of the health system;

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- Improvement in health system reporting including waiting times for outpatients and elective surgery, hospital accreditation status, and individual clinician and hospital performance and quality reporting.
 - These parliamentary inquiries have contributed substantially to shaping the policy debate on options for health reform. Probably of most significance was the 2000 Senate Inquiry into Public Hospital Funding - this generated a strong ongoing debate on the merits of pooling health funding between the Commonwealth and State governments. These health financing reform options are considered further in the next chapter.

3.1.2 Productivity Commission

Since 2000 the Productivity Commission has produced several major reports on health-related issues, covering the health workforce, medical technology, indigenous disadvantage, the economic implications of an ageing Australia and the 'red tape' associated with general practice. Appendix 2 summarises the key findings and recommendations of these reports.

Lessons and unfinished business

- The Productivity Commission has been very significant in presenting evidence on the case for health reform, as well as providing recommendations on reform options and directions. It provides a public forum and independent benchmark (an honest broker function), against which the efforts of governments can be assessed.
- Sometimes, the Productivity Commission is constrained in its influence due to the scope and nature of the reference given to it. For example, it did not issue recommendations on the more cost-effective use of medical technology as this work was undertaken as a research report.
- **The Commission's hardest-hitting recommendations on medical workforce have not been accepted by governments.** In particular, COAG has agreed to replacing state-based registration of health professionals with national registration, but has not agreed to establish a single national registration board that covers all health professionals. The Commonwealth Government has also not accepted the Productivity Commission's recommendations that:
 - An independent committee should advise on the safety, effectiveness and cost-effectiveness of medical and pharmaceutical services, and that
 - There should be an expanded range of services payable through Medicare when the service is delegated by a practitioner to another suitably qualified health professional.

3.1.3 Health Ministers

Commonwealth and State health ministers generally meet about twice each year, through the forum of the Australian Health Ministers' Conference (AHMC). Appendix 3 reports on the outcomes of these AHMC meetings since 2000.

Lessons and unfinished business

- Health Ministers have devoted considerable time to endorsing a large number of frameworks, strategies and plans to improve health service delivery (such as injury prevention or obesity). But, in the absence of dedicated funding or follow-up reporting on progress, **some of these national frameworks are no more than 'aspirational' and do not constitute real progress on health reform.**
- Health Ministers have made some progress in tackling other substantive issues (such as e-health and quality, although many stakeholders would argue that the rate of progress on these issues is too slow).

3.1.4 Council of Australian Governments

Between 2000 and 2005, health reform was not a high priority issue on the COAG agenda. In 2005 COAG essentially 'inherited' from Health Ministers what was then known as the health reform agenda that had commenced in 2002 during the lead-up to the negotiations on the 2003-2008 Australian Health Care Agreement. In April 2002 Health Ministers set up nine expert Reference Groups (involving clinicians, consumers and bureaucrats) to provide advice on reform opportunities under the next AHCA. The lack of apparent action in implementing the recommendations of these expert groups was the catalyst for the establishment of the Australian Health Care Reform Alliance. Following signing of the AHCA, health bureaucrats resumed working on developing specific proposals under the nine action areas. In June 2005 this reform agenda was forwarded to COAG for their endorsement.

The June 2005 COAG health reform agenda was principally organised around fixing 'interface' issues due to overlapping roles and responsibilities of Commonwealth and state governments. COAG agreed that further work should be undertaken to improve the health system in the following nine areas:

- Simplifying access to care services for the elderly, people with disabilities and people leaving hospital;
- Helping public patients in hospital waiting for nursing home places;
- Helping younger people with disabilities in nursing homes;
- Improving the supply, flexibility and responsiveness of the health workforce;
- Increasing the health system's focus on prevention and health promotion;
- Accelerating work on a national electronic health records system;
- Improving the integration of the health care system;
- Continuing work on a National Health Call Centre Network; and
- Addressing specific challenges of service delivery in rural and remote Australia.

COAG asked for detailed action plans to be developed on these issues by December 2005. However, this (old) health reform agenda was then 'rebadged' and subsumed into the National Reform Agenda (NRA) that was agreed and announced in February 2006.

The National Reform Agenda shifts the policy focus from resolving intergovernmental roles and responsibilities to achieving economic growth through human capital reform (higher participation and productivity of the workforce), a renewed focus on competition and a reduction in regulatory burden. The (new) health reform agenda, which forms part of human capital reform, has been reconceptualised so that the major focus is on keeping people healthy through health promotion and disease prevention. **This is quite a fundamental shift.** Over the past twenty years, most of the 'health reform' discussions have been about health system financing and governance, not about specific initiatives to improve the health of the population.

Appendix 4 summarises the reform proposals and initiatives announced by COAG in the past two years. These have been identified as falling under either the 'old' roles and responsibilities agenda or the 'new' health improvement agenda.

Lessons and unfinished business

- The 'new' health improvement reform agenda has been more generously funded than the 'old' roles and responsibilities agenda. The majority of the

new investment has been achieved through expanding the services that can be funded by the Commonwealth Government under Medicare (mental health, health checks).

- Investment under the 'old' roles and responsibilities health reform agenda has tended to be used to generate new, time-limited programs, that continue the blurring and shared responsibilities of governments for health service provision.
- With the exception of initiatives that affect the MBS, much investment in health reform is staccato or short-term. This has obvious implications for ongoing service delivery.
- The proposals funded under the new health improvement reform agenda are limited in scope (that is, diabetes prevention and management, health check for 45 year olds, and some lifestyle/risk factor initiatives). As yet, they do not constitute a quantum shift or rebalancing of the health system away from curative health services and towards health promotion and keeping people healthy.
- The health reform agenda is continuously being redefined, with new problems sometimes generating new programs and extra investment. However, there is little public reporting or evaluation undertaken of the effectiveness of what has been achieved and what still remains to be tackled.
- In this context, the new health improvement reform agenda may not be sustained due to its piecemeal nature. Outside the already announced funded proposals, **the health improvement reform agenda is not supported by a comprehensive vision and detailed work plan to channel reform activities over the next five to ten years.**

3.2 Progress on private health sector reform

Since the 1997 report by the Industry Commission into the private health insurance sector, the Commonwealth Government has undertaken many initiatives to enhance private health insurance, and hence, the private hospital sector. This has been driven by the view that a sustainable private health sector provides choice and complements the public hospital system, jointly funded by Commonwealth and state/territory governments. Appendix 5 outlines the major reforms to private health insurance introduced by the Commonwealth Government over the past decade.

Lessons and unfinished business

- The Commonwealth Government reforms have increased the share of the population with private health insurance. However, some stakeholders question whether the Commonwealth Government should be regulating for greater efficiency, access and quality of health service in the private health sector in return for its investment through the health insurance tax rebates.
- To date, there has been little emphasis on microeconomic reform of the private health sector. For example, efficient purchasing arrangements are constrained as doctors are not directly employed by private hospitals, yet strongly influence the range and volume of services provided in the private health sector.
- The recent introduction of Broader Health Cover insurance products has the potential to fundamentally change the private health sector, through encouraging the development of more health services provided outside hospital with a greater focus on prevention and keeping people healthy. However, the voluntary basis of these reforms may reduce their effectiveness in contributing to the health improvement agenda being driven by COAG.

3.3 Progress on reform of Commonwealth funded health services

The Commonwealth Government is the major funder of health services in Australia. It accounted for 45.6% of total spending on health services in 2004-05, compared with spending by state and territory governments of 22.6% and non-government spending (individuals, health insurers, injury compensation insurers) of 31.8%²¹. Appendix 6 outlines Commonwealth Government reforms introduced since 1996 to programs where it contributes significant funding.

Lessons and unfinished business

- The Commonwealth Government does not directly operate health services, meaning that its reform levers are generally tied to its purchasing power.
- Many of the initiatives have focused on reforming medical payment arrangements. These have included expanding the types of health service providers covered under the MBS to include practice nurses, allied health and psychologists, together with financial incentives to promote better care of patients with chronic conditions.
- There is scope to expand the take-up and coverage of some of the reformed medical payment arrangements relating to chronic care and multidisciplinary models of care.

3.4 Progress on reform of State funded health services

Reform of health services at state and territory level has been driven, at least partly, through numerous inquiries and reviews. Appendix 7 summarises some of the significant themes and outcomes arising from the major reviews in each of the states and territories since 2000.

Some of the commonly used reform initiatives have included:

- **Hospital demand management:** Strategies have included the use of programs to manage patients with chronic disease in the community and reduce avoidable hospital admissions through prevention programs (such as falls prevention programs or immunisation for at-risk groups). Another common approach has involved substantial re-engineering of business processes (such as only admitting patients to hospitals on the day of their procedure with pre-admission workups done on an outpatient basis).
- **Governance and service configuration reforms:** Jurisdictions have moved through cycles of centralisation and devolution in the relationship between health services such as hospitals and health departments. They have also used larger groupings of health services (Area Health Services or networks) to foster greater collaboration and clarity of roles across health services (for example, defining the levels of obstetric services that can be safely provided in different types of hospitals).
- **Innovative service models:** There has been considerable change in where health care services are provided and who provides them. Dialysis and chemotherapy are now commonly available in community-based settings including patients' homes. There has been more limited success in introducing new types of health service providers (such as nurse practitioners) or substituting between different types of health professionals.
- **Purchasing reforms:** There has been simultaneous uptake of both casemix and population-based approaches to funding, with many jurisdictions using a blend of these approaches. Many jurisdictions have also used centralised purchasing for health supplies and medical equipment and adopted system-wide approaches to the introduction of new medical technology and high-cost pharmaceuticals.

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- **Quality and safety reforms:** Many jurisdictions have worked to strengthen clinical leadership, with examples including the Clinical Excellence Commission in New South Wales or the Clinical Senate in South Australia. There has been variable uptake of other quality initiatives such as clinical incident reporting, credentialing and scope of practice reforms, and break-through collaboratives.

Lessons and unfinished business

- States and territories have engaged in policy learning from one another, with the frequent decision to use interstate experts to chair major health system reviews contributing to the transfer of health system reform proposals across jurisdictions. Mobility of the health clinical and management workforce also encourages the interstate dissemination and uptake of reform initiatives.
- However, there is not uniform uptake or implementation of health reform proposals across jurisdictions. For example, Queensland has taken the lead in publishing information on the clinical quality of care at individual hospitals, an innovation that is yet to be taken up by other states and territories.

4. Who is advocating for health reform and what are the major reform proposals?

While there has been some progress and much debate on health system reform, there is still a strong appetite for further reform. Many organisations and individuals are actively promoting their vision for a reformed health system. **The purpose of this section is to outline the major health system reform proposals that have been developed by leading stakeholders.** Of course, everyone has a 'stake' in how our health system performs – whether they are consumers of health care services, health professionals involved in delivering care, managers operating health services such as acute hospitals, citizens involved in paying taxes or meeting health care costs directly, funders of health services including governments and health insurers, and businesses who want access to a healthy, productive workforce.

This section does not include or comment on the health policies of the major political parties, some of which were being released and debated as the paper was being finalised. **Governments and oppositions respond to the views of stakeholders and it is the reform proposals of these health stakeholders that are presented below.**

Reform proposals have been included on the basis of being multi-dimensional and of national interest, rather than reform proposals focussing on single issues or the local delivery of health services. This section represents an analysis of stakeholder views based on published policy statements, media releases and submissions as at July 2007.

Given the volume and range of reform proposals that have been developed, they are organised below into three main categories:

1. Reform principles and goals;
2. Reform proposals that are based around targeted actions; and
3. Reform proposals that involve major changes to health financing and/or governance of the health system.

4.1 Reform principles and goals

Several stakeholders have developed high-level principles or goals for reform. These principles can be used to 'score' more detailed reform proposals and/or assess the effectiveness of reform proposals once they have been implemented.

Three sets of principles stand out for their comprehensiveness and because they have been developed by broadly-based stakeholders, namely, the Australian Health Care Reform Alliance, the Australian Healthcare & Hospitals Association and the Consumers' Health Forum of Australia.

The Australian Health Care Reform Alliance (AHCRA) is, as its name suggests, one of the leading proponents of health system reform. AHCRA was set up in 2003 during the five-yearly negotiations between the Commonwealth and State governments on the Australian Health Care Agreement (the funding agreement for public hospitals). Frustrated with the slow pace of reform, AHCRA held a major summit on health reform at Old Parliament House in Canberra in August 2003. Since that time, it has continued to play a prominent role in publicising the need for reform through testimony to parliamentary inquiries, submissions and workshops to influence political decision-makers and proposals for greater community engagement and dialogue on health reform.

In 2007 AHCRA comprises 43 member organisations including consumer, clinical, health professional, health care provider and academic organisations. This includes many national peak health provider associations (such as Catholic Health Australia, the Australian Healthcare & Hospitals Association, the Australian Nursing Federation and the Royal Australasian College of Physicians) and prominent consumer and community groups (such as the Australian Council of Social Service, CHOICE, the Health Issues Centre and

the Country Women's Association of Australia). The breadth of interests participating in AHCRA is quite unprecedented and makes its contribution to health reform discussions potentially highly influential.

The reform principles adopted by AHCRA at its 2003 summit are presented in Figure 3. These high-level principles have formed the backdrop, against which AHCRA (or leading participants in the Alliance) have developed more detailed and specific reform proposals that are discussed in the next section.

Figure 3: Australian Health Care Reform Alliance – reform principles²²

Australian Health Care Reform Alliance – reform principles

In its 2003 Blueprint for Health Reform Communique, AHCRA identified a suite of reform principles as follows:

- **Universal Access** – in a timely fashion, to an appropriate service, available because of health needs, not one's 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 the needs of Australians wishing to 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** and investment 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; and
- **The health workforce must be valued** and appropriately supported.

Another stakeholder with a strong interest in reform is the Australian Healthcare & Hospitals Association (AHA), the peak industry association for the public and not-for-profit health sectors. It has identified a suite of seven guiding principles for health reform (Figure 4). These reform principles are intended to shape the response to what AHA has determined to be five strategic challenges facing the health system, namely:

- Improving **equity of access and outcomes**: While equity of access was enshrined in Medicare (availability of services regardless of capacity to pay), the system has shifted over the last two decades with a greater focus on cost containment and cost effectiveness. The balance needs to be tilted back towards improving equitable access.
- **Engaging the community** in developing policy options: In the absence of clear objectives for the health care system, the community should be consulted and engaged in setting priorities for how resources are allocated.

- **Improving integration** of services: This relates to three dimensions – tiers of government (federal/state), type of care (acute, continuing and chronic, and preventative care); and public/private sectors.
- Improving **transparency on rationing**: An acknowledgement of resource constraints, coupled with greater transparency on the costs and benefits of health services, would allow a more informed community debate about spending on health care services relative to other priorities such as education, transport or tax cuts.
- Enhancing **evidence-based efficient provision of health services**: The health sector needs to encourage innovation and evidence-based policy making.

Figure 4: Australian Healthcare & Hospitals Association – reform principles²³

Australian Healthcare & Hospitals Association – guiding principles for reform

In its 2006-07 Policies, AHA identified seven guiding principles for the reform process, being:

- **Integrated planning** across jurisdictions, health care settings and professional groups;
- Clear **political accountability** for health care;
- Clear **accountability** of health care providers **to funders**;
- Clear **accountability for safety and quality** across all settings;
- Incentives geared to ensuring **care is given in the most appropriate setting by the most appropriate provider**;
- **Removal of incentives for cost-shifting**; and
- **Increased funding** for identified priorities.

Finally, the Consumers' Health Forum of Australia (CHF) is a national organisation that seeks to involve consumers in health program and policy development. Established in 1987, it has many health, disability and consumer groups as member organisations, with a reach of about one million Australians across a diverse range of health system issues and experiences. CHF has also developed a very comprehensive set of policy principles and reform criteria (Figure 5). Unlike the AHCRA and AHA reform principles, the CHF principles are targeted towards health financing reform proposals.

It is obvious, and not unexpected, that **there is reasonable commonality across these leading stakeholders in their reform principles or vision for health system reform**. Many other health stakeholders have also developed similar principles - there is certainly no shortage of guiding principles to shape the direction of health reform proposals. In the absence of an agreed national health policy, stakeholders have developed reform principles to serve as guide posts for whether the health system is improving or not.

4.2 Targeted reform proposals

While there is reasonable consensus on high-level goals for the health system (such as quality and universal access), **such broad reform principles do not lead to action unless they are translated into more specific reform proposals**. Decisions must also be made in selecting between competing, policy priorities. Again, many health stakeholders have developed detailed reform proposals, sometimes in response to parliamentary inquiries (such as the 2006 House of Representatives Inquiry into Health Funding) or for potential inclusion in government budgets or draft legislation.

Figure 5: Consumers' Health Forum of Australia – policy principles²⁴

Consumers' Health Forum of Australia – Policy Principles and Reform Criteria

To promote the effectiveness of health funding processes, CHF encourages the application of the following key principles:

- **Policy Principle 1:** The focus of health information technology (IT) initiatives should be on the problem to be solved rather than the technology to be utilised. The major problem to be solved is the health system fragmentation and lack of communication, particularly between hospital and primary care services, including general practice and community and allied health services.
- **Policy Principle 2:** Health IT reform must be coordinated, particularly in the area of unique patient identifiers and e-health records, and acknowledge and address consumer concerns about privacy.
- **Policy Principle 3:** Consumers support funding mechanisms and national policies about health service provision that are based on the delivery of accessible, safe, quality and effective services that meet patient needs. These needs may be related to treatment, care, prevention or health promotion.
- **Policy Principle 4:** Consumers support funding mechanisms and national policies about health service provision that are based on improving linkages between hospital services, primary health care, other health and community services and consumer and community groups.
- **Policy Principle 5:** All public and private health services should provide meaningful information to consumers about the quality and cost of the services they provide.
- **Policy Principle 6:** All states and territories should maintain a robust consumer health complaints mechanism that covers both public and private health care workers and services.
- **Policy Principle 7:** Evidence-based clinical practice must be the basis of initiatives to improve consumer safety and quality in treatment and care in the public and private health sectors.

CHF has also developed a set of criteria for consumers to use in assessing health financing reform proposals:

Universality – Does the policy recognise health care as a basic human right and build upon the universal access of Medicare?

Equity of Access and Outcomes – Does the policy promote equitable access to health services, and encourage equitable outcomes for all population groups in Australia?

Quality – Does the policy promote quality of care and focus on health outcomes as defined by consumers?

Transparency – Does the policy provide for information and accountability to consumers in terms of both cost and quality?

Affordability – Does the policy ensure the affordability of health services to consumers and the community and minimise the incidence of uncapped consumer co-payments?

Directness – Does the policy maximise the funding which goes directly to health service provision, and minimise the funding which is channelled to indirect sources such as public and private administration?

Value for money (technical efficiency) – Is the policy efficient and does it avoid “false” economies, such as cost shifting, unintended consequences and flow on effects?

Best use of money (allocative efficiency) – Does the policy encourage the allocation or reallocation of resources in ways which are likely to bring about equitable and optimal health outcomes?

Health creation – Will the policy contribute to the creation of a healthier community, rather than merely treating existing illness and/or injury?

Consumer participation – Have consumers been actively involved in the development of this policy? Will consumers be included as partners in implementation, monitoring and evaluation?

Reform proposals are sometimes characterised as being either ‘incremental’ or ‘big-bang’. This distinction has not been used here. **Reform proposals in Section 4.2 are identified as ‘targeted’ on the basis that they include proposals to change specific elements of the health system**, sometimes with potentially far-reaching effects. They have been separated from **the reform proposals in Section 4.3 that are primarily focused on changing the financing and/or governance of the health system and usually involve changes to the roles and responsibilities of the Commonwealth and state governments**.

There is clearly overlap with this approach. Historically, the health reform debate has tended to focus almost exclusively on intergovernmental financing of the health system. However, the difficulty in implementing changes to the financing and governance of the health system acts as a barrier to introducing other health reforms – an ‘all or nothing’ mentality. **A key challenge is to identify how we can achieve progress on targeted health reform proposals within the current health system design umbrella.**

The five targeted reform proposals outlined below represent some of the most commonly articulated and broadly supported reform directions for the health system. These proposals are not uniquely ‘owned’ by any stakeholder, with many groups interested in health reform sharing similar views about the key changes that should occur to improve health outcomes for the population. However, the Australian Health Care Reform Alliance’s specific proposals are included in some cases below, for illustrative purposes and in recognition of their broad-based coalition.

These proposals are:

- Creating a health system focused on prevention, promotion and wellness;
- Using priority setting and consumer engagement to drive health system change;
- Strengthening and remodeling primary health care;
- Creating a ‘high-performing’ and publicly accountable health system; and
- Ensuring fair and equitable access for all Australians (including Indigenous people, rural and remote populations, people with mental health problems).

4.2.1 Creating a health system focused on prevention, promotion and wellness

Almost every analysis of the challenges facing the health system (ageing, chronic disease, growing demand and consumer expectations) concludes that the health system can only be sustained if there is a fundamental shift to re-focus upstream on prevention and health promotion. The recent support by COAG for more investment in prevention, health promotion and disease management has given greater prominence to these issues.

There are a plethora of specific proposals about how to expand the focus on prevention, promotion and wellness. While some groups advocate primary prevention using broad population-based health promotion strategies, there is also strong support for interventions to reduce and better manage the risk of chronic diseases.

Some illustrative reform proposals falling under this broad grouping are as follows:

- The Australian Medical Association (among others) has recommended the creation of an overarching **Minister of Public Health** “to structurally shift the focus of the Australian ‘health’ system from disease to health and to prioritise reducing health inequalities”²⁵.
- The Australian General Practice Network has proposed **building upon the Medicare chronic disease payment system** to encourage GPs to treat obesity in its own right, rather than only intervening after the development of chronic diseases. The AGPN recommends that this involve multidisciplinary teams, care planning and affordable referral pathways to community-based support, advice and motivation²⁶.

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- Many organisations have advocated for strategies to **reduce risks and harms associated with consumption of tobacco, alcohol and drugs**. For example, the RACP has proposed greater use of taxation reforms, controls over liquor licensing and improved early intervention and treatment options²⁷.

4.2.2 Using priority setting and consumer engagement to drive health system change

The Australian Institute of Health Policy Studies focuses on enhanced consumer engagement as one of its five main research priorities. It has reviewed the literature and conducted interviews on how to improve consumer engagement in reshaping the Australian health system²⁸. Many other stakeholders are also actively pushing for a new approach to engaging citizens and consumers in making decisions about the future of the health care system. They are critical of the existing processes, arguing that organised interest groups dominate and that consultation occurs in a fragmented manner, often avoiding resource allocation issues.

This is not a new proposal. Back in 2000, a Senate inquiry on public hospital funding recommended that Ministers “commence a process of community consultation on health care issues, such as the values that should inform the development of a national health policy”²⁹. The Canadian experience³⁰, where a major health system review (the Romanow Commission on the Future of Health Care in Canada) was integrally shaped by a comprehensive, multi-faceted consumer engagement and consultation strategy, is often cited as a positive example that could be used in Australia.

The Australian Healthcare & Hospitals Association has recently included community engagement in the development of policy options as one of their five major policy goals³¹. This includes building community views into health reform processes, as well as involving consumers in improving the health system through their participation in health agency accreditation and assessment of health facility performance.

The Australian Health Care Reform Alliance has played a strong role in shaping the debate on consumer engagement. They are proposing a national dialogue “**to create a common set of values, principles and priorities for the health system of the future**. It could create the first national vision and framework for health care that all governments in Australia could use as the basis of the system.”³² The Alliance is recommending that a national consultation include: random samples of citizens; people who make frequent use of health services (such as those with chronic conditions); and groups who are hard to reach and/or have special needs (such as the homeless, people with disabilities).

Other elements of AHCRA’s proposal for community engagement³³ comprise:

- To be meaningful, consultation must be based on some essential principles. These include that consultation is: non-partisan and legitimate; transparent and run by an independent organisation; involve information-rich participants; be deliberative and meaningful (linking to genuine policy and decision-making processes); use a variety of methods; be sufficiently resourced and well facilitated; and be respectful of participants’ contributions and non-burdensome.
- There should be a range of non-traditional consultative methods used. These could include: **citizens’ juries, citizens’ deliberative councils or assemblies, consensus conferences, round tables, deliberative polls and televoting**. The focus should be on supporting deliberation with the objective of producing value-based choices.
- This national engagement process should be jointly run and funded by the Commonwealth and state governments. Joint involvement is important to ensure a common approach to health reform, rather than the multiplicity of existing government plans and frameworks.

AHCRA notes that some state governments are already using some of these approaches (such as citizen juries), but there is no national endorsement or funding to support a major engagement with the Australian community on the future of the health system.

4.2.3 Strengthening and remodeling primary health care

A strengthened primary health care system is often linked to proposals about reorienting health services from a curative to a preventive model.

The Australian Health Care Reform Alliance's *Action Plan for Health Care Reform*³⁴ has a strengthened primary care system as one of its five pillars for reform. The Alliance is advocating the development and agreement of a National Primary Health Care Policy, to be developed by governments in consultation with consumers and health professionals. AHCRA's action plan for reform of primary care includes the following elements:

- The establishment of new organisational models to delivery primary health care, based on **multidisciplinary care teams** that are either co-located or function as networks of health providers. AHCRA proposes building upon some existing models, together with trialing and evaluation of various multidisciplinary models of care. (Note: Strengthened primary care models are already being used in some jurisdictions, such as the Victorian Primary Care Partnerships and the HealthOne NSW partnerships across primary health and community care).
- **Funding models to support preventive care and health promotion.** This includes ensuring that primary care is adequately resourced to undertake health promotion and preventive health care, as well as the existing funding streams that are largely based on an illness model of health. AHCRA also supports funding community-based wellness models of health and extending funding to some primary care services, such as allied health, that currently receive no, or limited, public funding.
- **Improving the focus on quality and safety in primary care.** AHCRA has suggested that a national program of safety and quality in primary care be developed under the Australian Commission on Safety and Quality in Health Care. This includes ensuring that technology and clinical decision-making support tools are in place to provide primary care providers with the best available evidence.

4.2.4 Creating a high-performing and publicly accountable health system

There are many reform proposals that are targeted at improving the efficiency, cost-effectiveness, safety and quality of the health system. A further dimension involves enhancing consumer choice and accountability back to the community. Some of the targeted reform proposals in this domain involve translating successful achievements to other parts of the health system. Some of the specific reform proposals include:

- **Use of health system report cards:** Some countries, including the United States, make much greater use of publicly available performance information to allow consumers to compare and choose between different health providers (including hospitals, doctors and other health professionals). Catholic Health Australia has proposed that a task force be established to develop a system of report cards "to provide consumers with the tools they need to make informed decisions about their care"³⁵.
- **Strengthened evaluation of health care technology:** Health researchers have proposed using linked administrative health care databases to systematically monitor adverse events and safety problems with new medicines and technologies³⁶. This would replace the existing archaic, voluntary schemes for reporting on adverse events.
- **Building cost-effectiveness into health purchasing decisions:** Many groups have advocated an expansion of the cost-effectiveness approach currently used in assessing new pharmaceuticals to other parts of the health system, including all medical services and devices such as cardiac pacemakers or cataract lens implants. This proposal received strong support from state

governments and some health stakeholders when it was suggested by the Productivity Commission in its health workforce inquiry³⁷.

- **Greater use of information technology to improve the safety and efficiency of health care service provision:** There is widespread agreement that a national electronic health record system would be a major benefit, enhancing continuity of care for patients, reducing the risk of adverse events and lessening the duplication of medical tests across different providers. In addition, John Menadue has estimated that the effective implementation of health information technology could generate savings of 10 per cent equivalent to \$9 billion of Australia's total health spending³⁸.
- **Greater flexibility and substitution across the health workforce:** Following on from the Productivity Commission's health workforce inquiry, many stakeholders have developed specific proposals to drive workforce reform. For example, Stephen Duckett has suggested: amending the Medicare Benefits Schedule to increase the range of items which do not require personal provision by doctors; introducing powers of delegation within health professional registration legislation; and opening up the MBS and PBS arrangements to give other professionals access to test ordering and prescribing authority³⁹.

4.2.5 Ensuring fair and equitable access to health services for all Australians

Section 2.1 documented some of the problems with access to health services, with access problems being experienced most strongly by particular population groups in Australia. Many factors are associated with reduced access to health services including socioeconomic disadvantage, geographic location, Indigenous status and country of birth. In addition, people with certain health conditions may also struggle to get access to necessary health and support services (as evidenced, for example, by numerous inquiries into mental health services).

There are many reform proposals to improve access arising from stakeholders and other peak associations representing populations that experience such disadvantage. Examples of some reform proposals include:

- **Rural access:** The Rural Doctors Association of Australia has proposed that the Commonwealth Government enshrine an overarching Rural Service Obligation⁴⁰. This extends the analogy of community service obligations for access to telephones to setting minimum service obligations for access to rural doctors, local hospitals and rural health services. The RDAA has developed a menu of specific reform measures that could be implemented to give substance to the broad Rural Service Obligation commitment.
- **Services for low income populations:** The Australian Council of Social Service is advocating for the 'renewal' of adult dental care, with eligible low income adults able to receive a comprehensive oral health check every two years⁴¹. It has also called for greater investment in primary health care centres, "targeted to areas of greatest need, including areas of high unemployment and other indicators of social disadvantage, remote and rural areas, and areas of high populations of Indigenous people"⁴².

Obviously, there are also numerous proposals to improve the health of Indigenous populations, given that they experience the worst health outcomes of all Australians.

4.3 Financing and governance reform proposals

In 2000 the Senate Inquiry into Public Hospital Funding considered several proposals for major reform of the financing and governance of the Australian health system. Since that report, there has been extensive interest in, and further development of, proposals that involve significant changes to the intergovernmental framework of our health system.

The major financing and governance reform proposals are much more heterogeneous, with much less consensus on agreed reform directions, than the targeted reform proposals that have just been discussed. As many of them involve changes to the federal division of responsibilities, they are generally highly contentious. Support among stakeholders for some of these proposals often shifts according to the political climate.

The most commonly discussed major reform proposals are outlined below. They have been grouped according to whether they primarily relate to governance reforms, financing reforms, or joint governance and financing reforms. Once again, this distinction is somewhat artificial as some of these proposals overlap and interrelate, but **this grouping highlights the arenas that can be used to drive health system reform.**

4.3.1 Reform proposals mainly relating to governance

There are many variations on the theme of improving governance of the health system. Some of these proposals seek to improve how the existing players govern and manage the health system, while other proposals seek to substantially shift responsibility for governance to new bodies. These proposals, grouped on a scale of increasing magnitude of change, include:

- **Joint performance management:** South Australian officials⁴³ have recently proposed the establishment of a Health Performance Council, that would report on performance of the whole South Australian health system. This is intended to recognise the close relationship between health services funded by the Commonwealth and state governments. Another key element of this proposal is that the Health Performance Council would report directly to the Health Minister. **The concept of an independent performance assessment body, outside the existing health bureaucracies, is a recurring theme across the reform proposals of many stakeholders.**
- **A reinvigorated COAG or similar body:** In 2004 the Allen Consulting Group proposed that COAG be replaced with a new 'Australian Federation Council'. ACG's view was that comprehensive reform could only be "effectively driven by institutionalising true collaboration at the highest level of our Federation"⁴⁴. But, the vehicle or remedy to achieve 'true collaboration' is yet to be identified. In a similar vein, **the Business Council of Australia argued in 2006 for a revamped COAG**⁴⁵. This would include: scheduling COAG meetings at least twice each year with full-day meetings to allow proper consideration of policy issues; and the creation of an independent and adequately resourced COAG Secretariat.
- **A National Health Reform Council:** In its 2003 Communiqué, the Australian Health Care Reform Alliance called for the establishment of a National Health Reform Council to provide Australia with high-level independent policy advice. The Council would be jointly funded by Commonwealth and state governments, but would be structured as a partnership of Federal and state senior policy personnel, clinicians and other health and community care service providers, technical experts and consumers⁴⁶. Among other functions, the Council would be responsible for setting targets and benchmarks for overall health system performance against agreed principles and goals. **It would also publicly report on progress on health system reforms against outcomes and targets, an important role that many stakeholders believe is not adequately built into our current health system.**

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- **An Australian Health Care Reform Commission:** John Dwyer, who heads the Australian Health Care Reform Alliance, has also supported another closely related variation. While the National Health Reform Council might provide ongoing independent policy expertise, the Australian Health Care Reform Commission would be a short-term, stepping stone to more substantive changes to health financing. That is, Dwyer has suggested that the Commission would not generate health policies, but work on implementation of strategies that would facilitate and embed a move towards pooling of Commonwealth and State funding for health services⁴⁷.

In summary, there are many options to strengthen governance arrangements for health services. Some options involve giving existing entities more 'governing clout', while others involve the creation of new bodies that subsume functions (such as planning, performance management, policy development) of government health bureaucracies.

4.3.2 Reform proposals mainly relating to health financing

Many health financing proposals also involve significant changes to intergovernmental arrangements, and these are discussed in the next section. However, there are some proposals that are mainly about reforming health financing arrangements. These include:

- **Changes to private health insurance financing:** There are several proposals flowing from concerns about the effectiveness of the existing government rebate for private health insurance.
 - At one end of the spectrum, the **Australian Healthcare & Hospitals Association** has called for the rebate to be "paid directly to public hospitals on the basis that this will more effectively decrease public hospital waiting times"⁴⁸.
 - The **Australian Nursing Federation** has argued that a viable private health sector is important, but that this objective would be better met through the Commonwealth Government directly subsidising private hospitals, rather than using health insurers as intermediaries⁴⁹.
 - In the opposite corner, **Catholic Health Australia** has proposed stronger financial incentives and penalties to encourage private health insurance membership⁵⁰. This includes increasing the tax penalty for high income earners without private health insurance to 2 per cent of taxable income and increasing the Lifetime Health Cover loading of 2 per cent for each year of age over 30 to 3 per cent. The latter element is intended to recognise the higher risks or health costs for older populations.
 - The **Australian Council of Social Service** has proposed removing the exemption from the 1 per cent Medicare Levy surcharge for high-income earners who take out private health insurance⁵¹. They argue that the additional revenue generated could be used to fund greater investment in Indigenous health, oral health and community-based health care services in areas of low service supply. Under their proposal, the removal of the exemption would be accompanied by changing the income threshold to a flat \$75,000 for single people, couples and families.
 - Many stakeholders (including the Australian Council of Social Service, the Democrats and some health economists) have advocated removing the 30 per cent rebate from ancillary health insurance on the basis of inequitable government support for privately insured and Medicare patients. The most commonly cited example relates to dental services.
- **Changes to public hospital financing:** These proposals are often developed in the context of the five-yearly negotiations between the Commonwealth and state governments on funding public hospitals through the Australian Health Care Agreements. Some recent proposals include:

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- The **Australian Healthcare & Hospitals Association** has called for the Commonwealth Government to “match its funding increases to the private sector with a similar increase to public hospitals”⁵². Some groups have expressed this in terms of the Commonwealth indexing its funding to states for public hospitals in line with annual increases approved by the Commonwealth Government for private health insurance premiums.
 - The **Rural Doctors Association of Australia** (and some National Party politicians) has argued that public hospital funding under the Australian Health Care Agreement should be split, so that a specific amount should be allocated to rural areas⁵³. As the AHCA negotiations commence, other stakeholders also tend to argue for specific allocations (whether it be mental health or palliative care).
 - **Catholic Health Australia** has suggested that the Commonwealth Government enter into specific funding arrangements with privately owned public hospitals (such as St Vincents or the Mater)⁵⁴. Again, this direct contracting would be an alternative to existing intergovernmental funding through the Australian Health Care Agreement.
- **Other health financing proposals:** Other proposals to change health financing arrangements tend to be cyclical, often arising in response to major parliamentary inquiries. Several groups (including the Australian Medical Association and some health economists) have suggested consideration be given to trialling **medical savings accounts**. The core of these proposals involves individuals directly managing an account to pay for their own health costs, hence replacing both Medicare and private health insurance arrangements. The main rationale for medical savings accounts is about enshrining personal responsibility and creating incentives for more cost-effective and efficient use of scarce health care resources. Variations on the medical savings account proposals include accessing **superannuation savings** to pay for health costs, an idea that has been developed previously by Vince Fitzgerald of the Allen Consulting Group.

4.3.3 Proposals for governance and financing reform

Proposals in this category are what are often referred to as ‘big bang’, involving fundamental reforms to the health system. These types of proposals have been canvassed and debated in forums including Parliamentary inquiries, Productivity Commission meetings and in the health policy literature. Some of the most commonly discussed proposals are outlined here.

- **Podger’s Model Health System for Australia:** Andrew Podger, a former Secretary of the Commonwealth Department of Health and Ageing, has developed a reform proposal based on the Commonwealth taking full financial responsibility for the health and aged care systems⁵⁵. Other stakeholders have advocated Commonwealth financing of public hospitals, but the Podger proposal is much broader and would involve the Commonwealth assuming purchasing responsibility for all health and aged care services (including mental health, community health, public hospitals and other services currently funded by state governments). Key elements of the Podger model include:
- There would be negotiations to transfer funding and management responsibility for services currently under the responsibility of state governments.
 - Regional purchasing authorities would be established and have responsibility to meet the health needs of regional populations, with strong local advisory boards. They would receive budgets from a national health payment agency, with some national role also in pricing and payment issues (including setting co-payments).

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- At the national level, there would be separate entities responsible for policy development, health sector regulation, health research and evaluation, health payments, and operational issues.
 - **Menadue's Joint Commonwealth-State Health Commission⁵⁶:** John Menadue has chaired health system reviews in NSW and South Australia and has been active in developing reform proposals through the Australian Health Care Reform Alliance and through New Matilda. This proposal involves joint management and funding of health services by a new joint governance structure, and is one example of a 'funds pooling' proposal. Key elements include:
 - A joint commission could be introduced bilaterally with any willing state, rather than waiting to reach agreement across all jurisdictions. The Commission would be tasked with purchasing services from health providers under a joint strategic plan and with health system performance monitoring and reporting. However, the Commonwealth and State Health Ministers would retain responsibility for negotiating high-level policy principles and overall funding levels.
 - One objective would be to depoliticise health by shifting responsibility for resource allocation and purchasing decisions from Ministers to an independent Joint Commission.
 - Another objective is to encourage cost-effective substitution of health services, rather than continuing funding along program lines. Menadue notes that this would require pooling of all health programs including the MBS and PBS so that "budget holders can choose the best therapies".
 - **Fitzgerald's Integrated Health Care System:** The Fitzgerald proposal⁵⁷ builds on a 2004 report by the Allen Consulting Group for the Victorian Government that explored opportunities for ways in which governments could work better together. This proposal shares some of the elements of the Menadue model, but does not involve governments ceding responsibility to an independent commission. Key elements include:
 - There is a strong role for strategic purchasing, driven by the objective of improving coordination of care for patients. This involves funds pooling with purchasers responsible for the health of designated populations.
 - Regional purchasing agencies within states would be allocated pooled Commonwealth and state funding on the basis of risk-adjusted capitation payments, reflecting the expected costs of their population's health needs. In turn, they would enter into service agreements with health providers.
 - The Commonwealth and state governments would share responsibility for broad health policy development, budgets and resource allocation formula, core service specifications, overall design of an integrated health system, and setting the parameters for the operation of regional purchasing agencies.
 - An Australian Health Commission would be established to drive this reform process.

5. Next steps – taking action on health reform

Where to from here?

This report has canvassed the breadth of health reform activity currently underway including identifying considerable 'unfinished business'. There is no shortage of bright (and achievable) ideas to make our health system work better. **However, many valuable recommendations to improve the health system, emanating from government inquiries or stakeholder submissions, have not been acted upon.**

- **Some have simply been ignored by governments** – such as the Inquiry into Health Funding's recommendation for a national health policy. Of course, this call for a national health policy is not new, with this recommendation emerging time and time again in many inquiries, including in some of the Productivity Commission's reports on the health system⁵⁸.
- **But what are equally disturbing are the reform proposals that have notionally been accepted, but have not been translated into action.** In many cases, governments have adopted or accepted recommendations to improve the health system, but have not provided the investment or other resources necessary to achieve the agreed changes. In this category are many of the 'aspirational' service improvement frameworks or health strategies regularly endorsed by Health Ministers. But even specific commitments do not always proceed. Some fail due to lack of funding; some fail because the commitments were never followed through with implementation plans; some fail because of the intransigence that often characterises Commonwealth/State negotiations; some fail because of a lack of accountability and reporting back on the outcomes of Ministerial decision-making.

A recent report on Commonwealth-state responsibilities for health argued strongly that **"health reform and structural reform of the health system are not one and the same thing"**⁵⁹. This important distinction is at the heart of how we now move forward to progress health reform. Structural reform is not, and should not be, an end in itself. The Council of Australian Governments has adopted this approach in moving away from viewing 'health reform' as simply being about discussions on intergovernmental roles and responsibilities for health service delivery and financing to a new health improvement agenda, focussed instead on health outcomes.

This Discussion Paper has followed this approach in identifying that **health reform can occur through many channels that do not all involve the prism of Commonwealth-state relations.** Reforms can be targeted towards expanding the role of prevention and health promotion, improving the efficiency, effectiveness and quality of health services and redressing inequitable access to health care services. Many improvements can be made through collaboration between governments and health service providers. Even within the so-called 'big bang' reform options, separating governance, financing and other reform elements can create opportunities to introduce change without major overhaul of our federation. It is important to recognise that improving health outcomes does not require an 'all or nothing' approach to how we finance and organise the health system.

The targeted reform proposals identified in Section 4.2 provide a solid framework of reform directions that should be used to guide future work. These proposals are broadly supported and also have the advantage of being able to be substantially implemented within the existing health system design umbrella.

The Australian Institute of Health Policy Studies (AIHPS) believes that governments now need to show leadership in taking action to:

1. Create a health system focused on prevention, promotion and wellness;
2. Strengthen the role of primary health care;
3. Create a high-performing and publicly accountable health system; and

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4. Ensure fair and equitable access to health services for all Australians (including Indigenous populations, rural and remote populations, and other groups).

These reform directions provide the broad 'content' of health reform. However, it is all too evident from this Discussion Paper that **health reform often fails because the machinery of health reform is itself in need of reform**. Governments are not held effectively accountable for whether they live up to the commitments they make to improve the health system. **A contributing factor to this situation is that the business of health system reform often occurs behind closed doors with little opportunity for effective participation and engagement by the community**. First, the submissions or policy proposals of health stakeholders may be given little weight in shaping the content or timing of reform^a. Second, participation in the health reform debate has largely been limited to 'health stakeholder' groups, rather than individuals or broader communities of interest outside the health system.

The Australian Institute of Health Policy Studies believes that the machinery of health reform could be improved through implementing three 'reform pathways', as follows:

1. Embed the values and priorities of individual consumers into a strategic vision and national health reform agenda through engaging in a national consultation dialogue on what Australians want from their health system; and
2. Broaden participation in the development of health reform options through creating a broad community and business coalition to take a leadership role in shaping health reform options; and
3. Make governments more accountable for delivering real health reform through establishing an independent monitor to publicly report on progress in implementing agreed reforms to the health system.

Together these three reform pathways have the potential to transform and vastly improve our ability to achieve meaningful progress on health reform. **To stimulate debate, some ideas are presented on how these reform pathways might be translated into action**. These illustrate the potential for the three reform pathways to drive progress on health reform and are provided as a starting point for further discussion.

On the first reform pathway of consumer engagement, there are many well-developed and effective examples of large-scale engagement by consumers in shaping the values, principles and priorities for a future health system vision. The AIHPS, the Australian Health Care Reform Alliance and other groups have undertaken considerable research and developed clear roadmaps on how best to undertake a major consultation strategy with consumers on health system reform.

In the words of the Australian Health Care Reform Alliance:

*"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"*⁶⁰.

The Alliance has noted that **national consumer engagement on health system reform has successfully occurred on a major scale in countries including the United Kingdom, New Zealand, Canada, France and Sweden**. The elements of a consumer engagement process could include citizen juries, focus groups, consensus conferences and deliberative polling, all of which have supporting evidence and research as to their

^a A case in point was the AHCA Reference Groups set up in 2002 to allow health service, clinician and consumer participation in shaping reform priorities for the 2003-2008 AHCA's. When the AHCA's were signed, they contained little in the way of specific new commitments or deliverables on reform; instead reform continued to be discussed slowly behind the closed doors of meetings of Health Ministers and COAG).

effectiveness⁶¹. The Canadian experience is often cited, with the Romanow Commission on the Future of Health Care in Canada providing one excellent model of a comprehensive, multi-faceted consumer engagement and consultation strategy.

Consumer engagement is vital to shaping the values, principles and priorities for the future Australian health system, an important prerequisite to the development of a national health agenda. Investment by Australian Governments in a similar multi-faceted community and consumer engagement program would further open the health reform process to new participants, creating pressure for governments to take meaningful action on health reform.

On the second reform pathway of a community and business leadership coalition on health reform, there is always opportunity to enhance action on health reform through engagement of broader coalitions outside the health sector community. The National Reform Agenda and the Productivity Commission's economic analysis of the benefits of reform have generated new and legitimate interest from the business sector on how health reform is vital to improving participation and productivity.

The business community has been successful in giving greater prominence to, and broadening the debate on, reform of issues that were once considered outside their traditional scope of interest. One of the most recent examples is the Business Council of Australia's major report in August 2007 on boosting Australia's competitive advantage through reforming school education systems⁶². Often, this has involved partnering with thought leaders, researchers or stakeholders on reform options in these new areas of interest.

A new coalition across the business, community and health sectors would provide a strong new voice to shape the vision and drive action on health reform. **Ultimately, health reform is everyone's business, so participation in reforming the health system should involve broad coalitions of interest.**

On the third reform pathway of promoting greater accountability and monitoring of the progress of health reform, several options have been canvassed both in Australia and internationally.

In Australia **the business community has been particularly active in proposing options to strengthen the effective operation of COAG and Ministerial Councils** generally, with health reform being one potential beneficiary of such a strengthened approach. For example, the Business Council of Australia (BCA) has proposed several concrete actions to 'institutionalise cooperation' across governments including:

- Strengthening COAG through requiring at least twice yearly meetings and providing an independent secretariat;
- Strengthening Ministerial Councils through requiring annual work programs with defined performance indicators and requiring half-yearly reports by these Councils to COAG, and reporting to the public and community by Council on achievement of the performance indicators; and
- Establishing a Federal Commission to (among other things) report to COAG on "progress with implementing COAG agreed reform agendas"⁶³.

The BCA notes that there are several existing bodies such as the Productivity Commission, the new COAG Reform Council and the states' only body, the Council for the Australian Federation. Without debating the merits of particular organisations, the important message from the BCA's report is that the machinery of government (and hence implicitly health reform) could be strengthened through having an entity outside COAG to independently monitor whether governments are delivering real progress on reform.

Turning to international experience, **the Canadian health system provides a real-world, working model of using an independent monitor to drive greater accountability of governments for improving the health system.** In 2003 Canada's First Ministers (the equivalent of COAG in Australia) established the Health Council of

Canada to report directly to Canadians on progress on health system reform. The context was a major Health Accord or agreement in 2003, followed shortly after in 2004 by the comprehensive Ten-Year Plan to Strengthen Health Care. The Health Council of Canada works as follows:

- Every year, the Council publishes an annual report for Canadians that assesses what progress has been made on health system reform and what areas need more action. For example, in its 2006 report, *Health Care Renewal in Canada: Measuring Up?* the Council examines the broad areas of access to care, quality of care and population health. It identifies what governments promised to do, assesses what is known or unknown about actual progress on specific reforms, and finally advises what Governments should do next to live up to their commitments on health system reform.
- In addition to annual progress reports, the Council regularly releases other reports to keep Canadians informed about the status of changes in their health system. Recent reports have examined the impact on patients of waiting time guarantees, better management of patients with diabetes and the status of electronic health records.
- The Council meets five times a year, in different locations each time, so that Council members can meet and discuss health care issues with local communities. (It does not operate behind closed doors, like current meetings of Australian Health Ministers or COAG). The Council includes representatives of federal, provincial and territory governments, together with non-government representatives from a wide array of backgrounds. It operates as a not-for-profit corporation, with funding from Health Canada of about \$CA5 million in 2005-06.

There are enough parallels between Australia and Canada – including a federal system of government and universal public insurance – to make the Canadian model of monitoring and reporting on health system reform worth seriously considering for introduction in Australia. An Australian independent monitor of health system reform could report to COAG, have an independent secretariat, comprise broad membership including consumers, health providers, clinicians, academic experts, employers and the business community and government representatives, and be responsible for regular public reporting on progress against health system reform.

Together, these three reform pathways provide a solid foundation to drive strong and effective action on health reform in the future.

Appendix 1: Some of the recent federal parliamentary health inquiries, 2000-2006

National health inquiry	Major recommendations
House of Representatives Inquiry into Health Funding 2006 ⁶⁴	<ul style="list-style-type: none"> ▪ Governments should develop and adopt a national health agenda including: clarity re roles and responsibilities, long term sustainability, standards for health service delivery in rural and remote areas ▪ Public hospital funding reforms should include: funding to be linked to service demand and actual cost increases offset by an efficiency dividend; standards for equitable access should be defined; disaggregation of funding into streams with explicit policy objectives, outcomes and performance standards with such funding not subject to equalisation by the Commonwealth Grants Commission; consider using Medicare Benefits Schedule to fund public hospital outpatient and emergency department services ▪ Private health reform should include: an outcomes-based assessment of prostheses, improvements to informed financial consent and research on medical savings accounts ▪ Improve health system accountability and reporting including: elective surgery and outpatient waiting times; hospital accreditation; development of reporting on hospital and individual clinician performance and quality
Senate Select Committee on Medicare 2003 ⁶⁵	<p>Over and above general practice reform proposals (A Fairer Medicare and Medicare Plus), other recommendations included:</p> <ul style="list-style-type: none"> ▪ Commonwealth to renew funding support for public dental health services ▪ Establish independent review of equity and effectiveness of 30% private health insurance rebate and Lifetime Health Cover ▪ Consider Commonwealth Medicare grants to expand the community health centre model in areas of identified need and allow bulk-billing GP clinics near public hospitals ▪ Establish a new National Health Reform Council to consult with the community on the future of the health system
Senate Inquiry into Public Hospital Funding 2000 ⁶⁶	<ul style="list-style-type: none"> ▪ Reform health funding through pooling funding across all health programs into a single fund operating at a state level ▪ Establish a National Advisory Council to include major health sector participants in the development of new Commonwealth-State health funding arrangements ▪ Develop a national health policy informed by community consultation ▪ Establish a national statutory authority to improve the quality of the health system, including national performance indicators

Appendix 2: Recent Productivity Commission health-related inquiries, 2000-2006⁶⁷

Report	Key findings & recommendations
Australia's Health Workforce (2006)	<ul style="list-style-type: none"> ▪ Establish a single national registration board for all health professionals and set uniform national standards for registration ▪ Establish a single national accreditation board for health professional education and training ▪ Establish a health workforce improvement agency to promote systematic and timetabled adoption of workforce innovation ▪ Reform MBS payment arrangements including a new independent committee to review safety, effectiveness and cost-effectiveness of medical services and allowing more MBS services to be provided by non-medical health professionals
Impacts of Advances in Medical Technology in Australia (2005)	<ul style="list-style-type: none"> ▪ Medical technology is of varying cost-effectiveness, with relatively low use or access by some demographic groups ▪ Health technology assessment is fragmented along jurisdictional and sectoral (public and private) lines ▪ There needs to be better coordinated, more systematic health technology assessment, including reviewing the efficacy and cost-effectiveness once technologies are in use ▪ There should be a community debate about what is an appropriate level of subsidised access to health care
Overcoming Indigenous Disadvantage Key Indicators (2005)	<ul style="list-style-type: none"> ▪ There are mixed results in performance on improving Indigenous disadvantage ▪ There remains a large gap between Indigenous people and the rest of the population in all the headline indicators (e.g. 17 years lower life expectancy) and most of the strategic change indicators (e.g. two to three times the rate of infant mortality)
Economic Implications of an Ageing Australia (2005)	<ul style="list-style-type: none"> ▪ Health care costs are expected to rise to by about 4.5 percentage points of GDP by 2044-45, with ageing accounting for nearly half of the increase ▪ Increases in productivity and participation would enhance capacity to pay for costs of ageing, but ability to reduce fiscal pressure depends on extent to which service demands and costs continue to rise with growth ▪ More cost-effective service provision in health care would alleviate major fiscal pressure at its source
General Practice Administrative and Compliance Costs Study (2003)	<ul style="list-style-type: none"> ▪ Government policies and programs result in administrative and compliance costs of \$228 million, equal to 5% of GPs' total income ▪ About three-quarters of these costs are associated with quality improvement programs – the Practice Incentives Program, vocational registration and the Enhance Primary Care program ▪ Governments should: assess GP administrative costs in program evaluations; accelerate the use of information technology in reporting by GPs; and standardise information collection from GPs

Appendix 3: Outcomes of Health Ministers' meetings, 2000-2006⁶⁸

Year	Endorsement of frameworks, plans and strategies	Other more substantive health reform outcomes
2006	<ul style="list-style-type: none"> National Framework for Action on Dementia Obesity Action Plan & Physical Activity Guidelines for Older Australians 	<ul style="list-style-type: none"> Endorsed the release of a discussion paper on national safety and quality accreditation standards Signed a heads of agreement to establish a national health call centre network Agreed to remove legislative barriers to electronic prescribing and dispensing of medicines Agreed to a national scheme of portable medical registration to promote workforce mobility, with jurisdictions to use their 'best endeavours' to amend legislation by June 2007
2005	<ul style="list-style-type: none"> National Chronic Disease Strategy National Framework for Action to Promote Eye Health and Reduce Avoidable Blindness and Vision Loss Be Active Australia: A Framework for Health Sector Action for Physical Activity 2005-2010 National Injury Prevention Plan 2004 Onwards National Public Health Strategic Framework for Children 2005-2008 	<ul style="list-style-type: none"> Agreed to establish the Australian Commission on Safety and Quality in Health Care as of January 2006 Established the National e-Health Transition Authority with 3 year funding of \$18.2 million from 2005-06 (in addition to \$9.5 million for 04-05 work)
2004	<ul style="list-style-type: none"> National Health Workforce Action Plan National Oral Health Plan National Health Workforce Strategic Framework 	<ul style="list-style-type: none"> Agreed to a timetabled set of initiatives to improve patient safety in public hospitals Agreed in principle to a nationally consistent approach to medical registration
2003		<ul style="list-style-type: none"> Establish the Australian Health Information Council to provide advice on reform issues for information management and technology in health Implement reforms to improve radiotherapy services for cancer patients Establish a National Nursing and Nursing Education Taskforce
2002		<ul style="list-style-type: none"> Received the reports of the nine Reference Groups on a health reform agenda Agreed to implement reforms to ensure sustainability of medical indemnity arrangements
2001	<ul style="list-style-type: none"> National Alcohol Strategy and Action Plan 	<ul style="list-style-type: none"> Continued support for HealthConnect – a national health information network (\$37m funding) Investigate the establishment of a national blood authority
2000		<ul style="list-style-type: none"> Agreed in principle to develop a system of electronic medication records Provided \$5m for priority-driven health and medical research

Appendix 4: Status of COAG health reform proposals⁶⁹

'Roles and responsibilities' health reform agenda	Status of proposals
Health workforce	<p>Feb 07: Agreed to implement by July 2008 national registration for health professionals and accreditation of training and education programs.</p> <p>July 06: Package of initiatives (Commonwealth funding of about \$300 million over 4 years) including: Additional medical school places and higher education nursing places (with funding subject to bilateral agreement with relevant jurisdictions); formal recognition of rural medicine as a generalist discipline under Medicare; expansion of specialist training to new settings by January 2008; and biennial reporting to COAG on implementation of health workforce reforms. Note, however, that COAG has not agreed to implement all the recommendations arising from the Productivity Commission's report into the health workforce.</p>
Services for young disabled people	Feb 06: Establish a 5 year program (up to \$244 m in Commonwealth and state cost-shared funding) to mid-2011 to provide alternative accommodation options for young disabled people living in residential aged care facilities
Electronic health records	Feb 06: Agreed to invest \$130 million (Commonwealth and state cost-shared funding) to June 2009 to accelerate work on national electronic health records
Access to health advice	Feb 06: Signed a Heads of Agreement to establish a National Health Call Centre Network (Commonwealth funding of \$96 million and States funding of \$80 million) over 4 years
Access to services for older people	Feb 06: Commonwealth funding of \$168 million over 4 years to improve access to services for older people, including assessments, more services in rural areas, and better management of older people in public hospitals
Access to services in rural areas	Feb 06: Allow more flexible access to Commonwealth and state funding to improve access to primary care services in rural and remote areas
'Health improvement' health reform agenda	Status of proposals
Diabetes	Feb 07: Agreed to \$200 million package (Commonwealth and state cost-shared funding) for type 2 diabetes, but COAG still has to agree the specific activities that will be funded under this package. Agreed to develop by mid-2008 a nationally agreed risk assessment tool and other program tools relevant to diabetes prevention and management.
Mental health	July 06: Agreed on a National Action Plan on Mental Health (\$4 billion over 5 years)
Improving health status	Feb 06: Agreed to a \$500 million Australian Better Health Initiative program comprising: health promotion activities, implementation of a Well Person's Health Check available under Medicare, and services to reduce risk factors and improve lifestyles.

Appendix 5: Commonwealth Government health reforms, 1996-2006⁷⁰

Commonwealth Minister for Health and Ageing - speech on health reform, February 2007

“Since 1996, the Government has:

- Revitalised the private health sector and boosted insurance coverage from about six million to nearly nine million people
- Improved the Health Care Agreements to increase state government funding for state-run public hospitals
- Reformed the Pharmaceutical Benefits Scheme to make more use of generic drugs at better prices for taxpayers
- Allocated an extra 78,000 aged care places and provided more support for nursing home infrastructure
- Introduced a new Medicare safety net to help 2 million patients a year with high out-of-hospital, out-of-pocket costs
- Doubled the number of HECS-funded medical school places
- Increased Indigenous-specific health spending from \$100 million to \$370 million a year and increased Indigenous use of the MBS and the PBS from about 40 to about 60 per cent of the general population rate
- Thoroughly prepared Australia to deal with a possible bird flu pandemic
- Stabilised the medical indemnity insurance system (with the support of state tort law reform)
- Restored morale in general practice by boosting fulltime GPs average Medicare earnings by about \$50,000 a year since late 2003
- Boosted GP bulk-billing rates to 77.1 per cent and overall bulk-billing rates to 72.4 per cent (which is 1.4 percentage points higher than in 1995-96)
- Funded health checks under Medicare for middle aged people, people over 75 and Aborigines
- Introduced GP management plans for people with chronic illness
- Extended Medicare benefits to allied health professionals working under team care plans prepared by a GP
- Subsidised nurses to work in general practice
- Lifted childhood immunisation rates from 53 to 90 percent
- Expanded Medicare access to consultations with psychologists”

Appendix 6: Commonwealth reforms to private health insurance, 1996-2007⁷¹

Year of introduction	Reforms to private health insurance	Outline of health insurance reform
2007	Broader Health Cover	Regulation that allows private health insurers to cover more services provided outside hospitals that substitute for or prevent hospital care, including management of patients with chronic disease
2006	Medibank Private	Legislation foreshadowed to sell Medibank Private
2005	35% and 40% tax rebates	Increased rebate for older Australians – 35% for people aged 65-69 and 40% for people aged 70 or over
2000	Gap cover schemes	Regulation to boost the share of medical services provided in hospitals where patients have ‘no gap’ or a ‘known gap’
2000	Lifetime Health Cover	Higher premiums for people purchasing health insurance after the age of 30
1999	30% tax rebate	30% tax rebate for hospital and ancillary insurance (not capped or means-tested)
1997	Medicare Levy Surcharge	A penalty of 1% of taxable income for high income people who do not have private health insurance
1997	Private Health Insurance Incentives Scheme	A means-tested capped tax rebate for private health insurance members
1996	Review of private health insurance sector	Commissioned the Industry Commission to review the private health insurance industry with the aim of improving the overall economic performance of the Australian economy

Appendix 7: Major reviews of state health systems, 2000-2006

Health system review	Major review themes and outcomes
NSW: Report of the NSW Health Council (Menadue, 2000) ⁷²	<ul style="list-style-type: none"> ▪ Development of a metropolitan health service plan with stronger networking of services ▪ Strengthened clinical leadership including clinician involvement in specialty service planning ▪ Funding certainty through 3-year budgets with allocation of funding to Area Health Services using a resource distribution formula
Vic: Ministerial Review of Health Care Networks (Duckett 2000) ⁷³	<ul style="list-style-type: none"> ▪ Establishment of Metropolitan Health Services as new collaborative governance arrangements for metropolitan public hospitals ▪ Improving financial sustainability through establishment of centralised purchasing for health supplies ▪ Enhancing consumer input through creation of Community Advisory Committees for public hospitals
Qld: Queensland Health Systems Review (Forster, 2005) ⁷⁴	<ul style="list-style-type: none"> ▪ Shifting to clinician-led decision making with new empowered Area Health Services and downsizing of, central office functions ▪ Focus on clinical quality and improvement, credentialing and a new and strengthened health quality and complaints commission ▪ Workforce recruitment and retention including through extra funding
SA: Better Choices Better Health South Australian Generational Review (Menadue, 2003) ⁷⁵	<ul style="list-style-type: none"> ▪ Strengthening primary care through service networking ▪ Integration of individual health agencies into a small number of regional health services, with greater networking of clinical services and statewide health workforce planning ▪ Planning services at a population level with the use of a resource allocation formula to ensure geographic equity between regions
WA: A Healthy Future for Western Australians: Report of the Health Reform Committee (Reid, 2004) ⁷⁶	<ul style="list-style-type: none"> ▪ Designation of two tertiary hospitals and service reconfiguration with hospitals specialising in rehabilitation, mental health and aged care ▪ Reduced provision of outpatient services through tertiary hospitals with enhanced roles for non-tertiary hospitals and private practice ▪ Area Health Services with expanded responsibility for population health and mental health, together with the use of performance agreements between Area Health Services and the Department and use of resource allocation formula as basis of funding to Areas ▪ Expanded focus on health promotion, with use of the Health Call Centre to better support patients with chronic disease
Tas: The Tasmanian Hospital System: Reforms for the 21st Century (Richardson, 2004) ⁷⁷	<ul style="list-style-type: none"> ▪ Managing demand for elective surgery, dialysis and specialist medical care ▪ Service networking including use of a dedicated service centre approach for specialist services, together with sharing of technology and equipment across public and private sectors ▪ Strengthening workforce recruitment, retention and benchmarking of staffing levels for specialist clinicians
NT: Report of the Review of the Department of Health and Community Services (Bansemer, 2003) ⁷⁸	<ul style="list-style-type: none"> ▪ Abolition of the funder/purchaser/provider service delivery model ▪ Addressing financial sustainability through extra funding and bureaucratic downsizing ▪ Establishment of a Hospitals Network across acute hospitals to improve resource and workforce management

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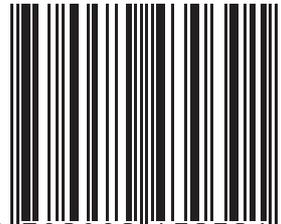
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ISBN 978-0-9804303-0-1



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