

A healthier future for all Australians: an overview of the final report of the National Health and Hospitals Reform Commission

Christine C Bennett

Health is important to every Australian. It is fundamental to our wellbeing and experience of life, as well as being critical to our national economy, national security, and, arguably, our national identity. We look to government for strong leadership on health issues. While the Australian health system has served us well and has many strengths, it is under growing pressure, particularly as the health needs of our population change. Many Australians face unacceptable inequities in access to services¹ and health outcomes.^{2,3} There are growing concerns about safety and quality, and inefficiency at many levels. We also face significant emerging challenges, including increasing demand for and escalating costs of health care, more people living with long-term and complex health problems, an ageing population, rising consumer expectations, and a stressed and stretched health workforce.

Our current health system has structural and systemic flaws that make it poorly equipped to respond to these challenges. It is fragmented, with a complex division of funding responsibilities and performance accountabilities between different levels of government. The federal and state governments have different capacities to meet the growing costs of services, and the current separation of responsibilities means that no level of government has a detailed understanding of all aspects of the health system, and that policies relating to specific responsibilities do not necessarily take account of the health system as a whole.

The case for reform is compelling, as is the readiness for change in the community and at the front line of health care. The National Health and Hospitals Reform Commission was formed to deliver a plan for long-term reform of the whole health system. Our final report, *A healthier future for all Australians*, sets out that plan and was presented to the Australian Government on 30 June 2009.⁴ The report's 123 recommendations are grouped in four reform themes:

- *Taking responsibility*: encouraging and supporting greater individual and collective action to build good health and wellbeing, by individuals, families, communities, health professionals, employers, health funders and governments.
- *Connecting care*: delivering comprehensive care for people over their lifetime.

ABSTRACT

- After extensive community and health industry consultation, the final report of the National Health and Hospitals Reform Commission, *A healthier future for all Australians*, was presented to the Australian Government on 30 June 2009.
- The reform agenda aims to tackle major access and equity issues that affect health outcomes for people now; redesign our health system so that it is better positioned to respond to emerging challenges; and create an agile, responsive and self-improving health system for long-term sustainability.
- The 123 recommendations are grouped in four themes:
 - Taking responsibility: supporting greater individual and collective action to build good health and wellbeing.
 - Connecting care: delivering comprehensive care for people over their lifetime, by strengthening primary health care, reshaping hospitals, improving subacute care, and opening up greater consumer choice and competition in aged care services.
 - Facing inequities: taking action to tackle the causes and impact of health inequities, focusing on Aboriginal and Torres Strait Islander people, people in rural and remote areas, and access to mental health and dental services.
 - Driving quality performance: having leadership and systems to achieve the best use of people, resources and knowledge, including "one health system" with national leadership and local delivery, revised funding arrangements, and changes to health workforce education, training and practice.

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- *Facing inequities*: taking action to tackle the causes and impact of health inequities.
- *Driving quality performance*: having leadership and systems to achieve the best use of people, resources and knowledge.

Our reform agenda aims to:

- tackle major access and equity issues that affect health outcomes for people now;
- redesign our health system so that it is better positioned to respond to emerging challenges; and
- create an agile, responsive and self-improving health system for long-term sustainability.

From the outset, the Commission's aim was to put people at the centre of the health system — to give them knowledge, choices, and the ability to make informed decisions about their health. We also considered people's collective needs, as taxpayers, to achieve the best health outcomes, quality of care and value for money by ensuring people can get the right care in the right setting, efficiently delivered without waste and duplication. We recognised that some people will have greater health needs or more difficulty accessing care. Equity, or “fairness”, must be at the heart of the Australian health system.

Tackling major access and equity issues that affect health outcomes for people now

Significant additional investment in health care services is required to close the gap in health outcomes between Aboriginal and Torres Strait Islander peoples and other Australians. We recommend that the Australian Government form a **new National Aboriginal and Torres Strait Islander Health Authority** to actively purchase and commission the best health services that are effective, high quality and culturally appropriate, and meet the needs of Indigenous peoples and their communities. We must also strengthen the vital role of community-controlled health services, train and recognise an Indigenous health workforce and a workforce for Indigenous health, and upskill our whole health workforce to provide culturally appropriate services.

For **people living in remote and rural areas**, universal entitlement to health care under Medicare does not always translate to universal access, due to the limited availability of doctors. Our recommendations aim to get services to people or people to the services they need, and include equivalence or “top-up” funding to match the resourcing of better served communities on a per capita basis, more flexible use of the health workforce, a range of supports and incentives to encourage health professionals to train and work in rural and remote locations, and increased funding for patient travel and accommodation assistance.

To ensure **better care for people with serious mental illness**, we need to provide access to a range of treatment and support services, connected across the spectrum of care. We recommend expansion of subacute services in the community and propose that all acute mental health services have a “rapid response outreach team” available 24 hours a day to provide intensive community treatment and support.

Nearly a third of Australian adults avoid or delay visiting the dentist because of costs; there are more than 650 000 people on public dental waiting lists;⁵ and the dental health of our children is getting worse.⁶ We are therefore recommending a **new universal scheme for access to basic dental services**, called “Denticare Australia”. Under this scheme, everyone would have the choice of receiving basic dental services (prevention, restoration, and the provision of dentures) paid for by Denticare through either a private health insurance plan or through public dental services.

One of the most high-profile areas of community concern relates to timely access to quality care in public hospitals, particularly poor outcomes due to overcrowding in emergency departments⁷

1 Preliminary set of National Access Targets*

Primary health care services: no more than 1 day to access a primary health care professional; no more than 2 days to access a medical practitioner

Health telephone support: no more than 10 minutes to receive initial telephone advice through the National Health Call Centre Network

Postnatal care: home visit to a new mother within 2 weeks of giving birth

Crisis mental health services: response within 1 hour for emergency patients, and within 12 hours for priority patients

Community mental health services: contact within 7 days of discharge from an acute mental health service for patients with psychosis, and within 1 month of referral for other patients

Drug and alcohol treatment program: within 1 month of referral

Aged care assessment: within 48 hours for patients requiring immediate response, and within 14 days for patients whose condition is deteriorating

Public hospital outpatient services: first appointment within 2 weeks for urgent patients with a life-threatening condition, and within 3 months for other patients

Radiotherapy: commencement of therapy within 1 day of referral for emergency care patients, within 2 weeks for high-priority patients, and within 1 month for other patients

Planned surgery: within 1 month for high-priority (Category 1) patients, and within 3 months for priority (Category 2) patients

Ambulance services: within 15 minutes for potentially life-threatening events in metropolitan areas

Emergency departments: immediately for resuscitation (Category 1) patients, within 10 minutes for emergency (Category 2) patients, and within 30 minutes for urgent (Category 3) patients

*These targets identify the maximum time within which patients should be able to access services; some patients may require treatment much more rapidly. The targets should be used in association with robust triage and urgency classifications, so health professionals can make decisions based on the particular needs of individual patients. ◆

and delays in access to planned surgical and medical admissions and specialist assessment.⁸ We recommend **additional funding for public hospitals with major emergency departments** to ensure there are sufficient available beds (ie, operating at about 85% occupancy) to enable timely access for people needing to be admitted from the emergency department.

To ensure an ongoing focus on appropriate access to services, we are recommending **National Access Targets across the continuum of health services**. Our preliminary set of targets is shown in Box 1; these should be subject to consultation and feedback from consumers and clinicians.

Redesigning our health system so that it is better positioned to respond to emerging challenges

Prevention and early intervention should be embedded into every aspect of our health system and our lives. Supporting a healthy start to life for every Australian child and improving our understanding and management of health risk across a person's lifetime (such as early detection and intervention of mental health issues presenting in young adult years) are fundamental to this approach.

Key to this paradigm shift towards prevention is the establishment of an **independent National Health Promotion and Prevention Agency**, which should have a broad role to drive change

in how Australians, and the health system, think and act about health, including through better education, evidence and research. The Agency would also consult with the community to develop and lead action on a set of **Healthy Australia Goals 2020**, which everyone can help to achieve.

Our health system currently works reasonably well for people with acute or emergency problems that can be resolved quickly through one-off medical interventions. However, the needs of people with chronic diseases or multiple complex health and social problems, and older, increasingly frail people are less well met. We need to redesign health services around people, so they can readily access the right care in the right setting. We believe that **strengthened primary health care services in the community**, building on the vital role of general practice, should be the “first contact” for providing care for most health needs of Australian people. Focusing on collaborative team care, our recommendations include:

- supporting the development of Comprehensive Primary Health Care Centres and Services that are open for extended hours and offer a broad range of services;
- voluntary enrolment of young families, Aboriginal and Torres Strait Islander people, and people with chronic and complex care needs (including disabilities or mental illness) with a “health care home” (similar to “medical homes”⁹ in the United States, which stress the value of access, continuity and coordination of care for patients), to broaden the scope of services available to them, including care coordination; and
- regional Primary Health Care Organisations (transformed from Divisions of General Practice) to support service coordination and population health planning.

We recommend that the Australian Government becomes responsible for all public funding of primary health care services, while states and territories continue as providers of services.

In **planning hospitals of the future**, we suggest that the separation of elective and emergency surgery would lead to greater efficiency, and that specialist outpatient services should be designed around changing health needs, with more of these services provided in community settings. Collaborative shared care between specialist and primary health care teams would be achieved through better communication and coordinated care pathways for people with long-term or complex health problems, such as cancer or diabetes, or people with intellectual disabilities.

There is an urgent need for substantial **investment in and expansion of subacute services**, including a major capital boost to build the facilities required. Subacute facilities could provide both “step-up” and “step-down” care, avoiding unnecessary hospital admission and restoring people to functional independence after an episode such as a stroke, a heart attack, or a fall.

Our recommendations to **open up greater choice in aged care services** aim to better meet the needs of older people, providing more flexibility and options, directing public funding to those in greatest need, and supporting a viable and responsive aged care provider industry.

Creating an agile and self-improving health system for long-term sustainability

Central to an agile, responsive health system will be the people it serves. We present ways to **strengthen people’s role in their own health** and enable a greater community voice by building health literacy, fostering community participation and empowering consumers. Similarly, **building a modern, flexible health workforce**

and engaging effectively with clinicians will be vital to a self-improving, innovative health system. Among our recommendations are “clinical senates”, a new framework for education and training of health professionals, a dedicated funding stream for clinical training placements, and the establishment of a National Clinical Education and Training Agency.

We recommend a **transformative e-health agenda** to drive improved quality, safety and efficiency of health care. The introduction of a **person-controlled electronic health record for each Australian by 2012** is an important systemic opportunity to enable person-centred care, support informed consumer decision making, improve quality and safety of care, reduce waste and inefficiency, and improve continuity and health outcomes for patients.

The **smart use of data and evidence** will also assist well designed funding and strategic purchasing — in other words, getting the most efficient and effective care through how we fund or pay for health services. Efficient activity-based funding for hospitals and new funding models supplementing episodic payments could reshape Medicare to focus beyond activity to quality care, timeliness and better outcomes.

We believe that our health system should be driven by a **strong focus on quality and continuous learning** in clinical practice and the implementation of evidence-based improvements to delivery and organisation of health services. **Investment in innovation and research** across all settings and professional groups is essential, and we have targeted action at both national and local levels.

A Healthy Australia Accord to create one health system

To ensure Australia’s health system is sustainable, safe, fair and agile enough to respond to people’s changing health needs and a changing world, we need to make significant changes to the way it is governed. We make two main recommendations on reforming the governance of our health system.

The first recommendation calls on the state premiers and territory chief ministers to agree to **create “one health system” through a new Healthy Australia Accord** that clearly articulates the agreed and complementary roles and responsibilities of all governments in improving health services and outcomes for all Australians. The Accord would significantly realign roles and responsibilities relating to funding and operation of health services.

We have defined a range of key functions that should be led and governed at a national level, including e-health, clinical education and training and health workforce planning, driving the prevention agenda, promoting and monitoring safety and quality, innovation and research, and health intervention and technology assessment.

New funding arrangements for elements of the health system would see the Australian Government responsible for 100% of the “efficient cost” (ie, achieving a desired outcome at the lowest cost through optimal use of resources) of public hospital outpatient services and, initially, 40% of the efficient cost of every public patient admission to a hospital, subacute or mental health care facility and every attendance at a public hospital emergency department. Efficient costs can be established by comparing the cost across different hospitals or services to deliver the same health service (eg, a normal birth). As the Australian Government builds capacity and experience in purchasing these public hospital and public health care services, this approach provides the opportunity for its share to be incrementally increased over time to 100% of the efficient cost of these services. In combination with the recommended full funding responsibility of the Australian Government

2 Indicative full-year costs of major reform initiatives

Reform	Annual cost (\$ million)
Prevention	100
Primary health care	883 to 1962
Hospitals	-138 to 917*
Aged care	874 to 1323
Indigenous health	70
Rural and remote health	217 to 514
Mental health	356
Oral health	320†
One national health system	167
Total	2849 to 5729

* Estimate includes enhancing subacute care services and is net of the estimated efficiency savings anticipated from introducing activity-based funding. † Implementing Denticare Australia would require a further \$3.9 billion, which could be offset by an additional Medicare levy of 0.75% of taxable income. ◆

for primary health care and aged care, these changes would mean the Australian Government would have close to total responsibility for government funding of all public health care services across the care continuum — both within and outside hospitals.

While we believe that there will be significant benefits of transparency, accountability and efficiency under the Healthy Australia Accord, and its implementation should commence now, we also believe there is a real need to further improve the responsiveness and efficiency of the health system and its capacity for innovation. It is our view that greater consumer choice and provider competition, and better use of public and private health resources have the potential to achieve this through the development of a uniquely Australian governance model for health care that builds on and expands Medicare. We have given this new governance model the working title “**Medicare Select**”.

Under this model, the Australian Government would be the sole government funder of health services. All Australians would continue to have a defined Medicare entitlement and could readily select to take that entitlement and appropriate risk-adjusted funding to one of a number of competing “health and hospital plans”, which could be operated by government, a not-for-profit organisation or private enterprise. The selected plan would be responsible for purchasing, commissioning or brokering services to meet that person’s Medicare entitlement across all aspects of health care. This may include services provided by public, private and not-for-profit health care organisations. This model requires further detailed development. We have recommended that the Australian Government commit to exploring, over the next 2 years, the design, benefits, risks and feasibility of implementing Medicare Select.

Investing in reform

Reform will require targeted investment. However, in assessing the financial implications of our reform plan, we must consider not only the recurrent and capital costs of the recommended initiatives but also the subsequent efficiency and productivity gains across the system, and the medium- and long-term impact on health

expenditure. We have estimated that the indicative annual costs of our major reforms, if fully implemented, would be between \$2.8 billion and \$5.7 billion. This excludes Denticare Australia and areas where spending has already been committed by government, such as the \$1.58 billion towards closing the gap in the health of Aboriginal and Torres Strait Islander peoples, and Council of Australian Governments funding committed to health workforce planning, education and training. Estimated costs for some of our proposed major reforms are shown in Box 2.

In addition, total capital investment of between \$4.2 billion and \$7.3 billion over 5 years would be required to transform the health system’s infrastructure. Capital investment is a critical enabler of a number of our reforms, including Comprehensive Primary Health Care Centres and Services (\$300 million); reshaping hospitals and enhancing subacute care facilities (\$2.25–\$4 billion); dental training and school dental services (\$0.5–\$1 billion); clinical education and training (\$100–\$150 million), and delivering an e-health agenda, including the person-controlled electronic health record and smart data and communication systems (\$1.2–\$1.8 billion).

The actual additional spending required will be determined by the pace of reform, as well as the extent to which funding can be redirected and prioritised, and progress in reducing inefficiency. Balancing this investment will be the expected improvements in patient care, access, efficiency and productivity of the health system. Redesign of our health system — including better access to subacute and aged care services and implementation of advance care planning — is estimated to free up about 2900 hospital beds, allowing public hospitals to provide about 160 000 extra episodes of care annually. Over the long term, the Australian Institute of Health and Welfare has estimated that our health reforms will slow the growth in health spending, reducing projected health spending by \$4 billion a year by the 2032–33 financial year.¹⁰

Conclusion

There is a genuine desire for reform of Australia’s health system. Based on our consultations across Australia, we know the community, health professionals and health services are ready to embrace reform. We urge governments to continue consultation and engagement with the community, health professionals and health services; and we encourage clinicians to play a leading role in the change process to come. The success of the reform agenda will depend on it. Change is more readily achieved, and with best results, when it is informed and owned by all of us.

Competing interests

None identified.

Author details

Christine C Bennett, MB BS, FRACP, MPaed, Chair,¹ and Chief Medical Officer²

¹ National Health and Hospitals Reform Commission, Canberra, ACT.

² Bupa Australia, Sydney, NSW.

Correspondence: christine.bennett@nhrc.org.au

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