A healthier future for all Australians: A submission in response to the final report of the National Health and Hospital Reform Commission

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About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care facilities are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.
Executive Summary

The Catholic Church in Australia oversees the provision of about 1 in 10 of the Nation’s hospital beds. Similarly, it provides 1 in 10 of all residential aged care beds, and thousands of care packages to older Australian's living in their own home.

Forming 10% of the nation’s health and aged care system, the Catholic Church argues reform is essential. For this reason, Catholic Health Australia has coordinated the response of Catholic health and aged care services to the release of the report of the National Health and Hospital Reform Commission. This policy paper is the response of 10% of the national health and aged care system to the recommendations of the Commission.

Catholic Health Australia endorses the work of the Commission. Specifically, we endorse the Commission's Recommendations to:

- Implementing within Australia the recommendations of the World Health Organisation’s Commission on Social Determinants of Health “Closing the gap within a generation”;
- Report publicly on health status, health service use, and health outcomes;
- Establish a National Health Promotion and Prevention Agency;
- Renew effort to establish personal electronic health records;
- See the Commonwealth assume responsibility for all primary health care policy, including the proposed investment in primary health care infrastructure;
- Enable voluntary enrolment with a single primary health care provider for people with specific health needs;
- Create National Access Guarantees and comparable public reporting for hospital access;
- Implementation of nationally consistent activity based funding for hospital services;
- Aged Care subsidies for both residential and community care being made available via a universal entitlement to all who need them, in place of the current rationed allocation;
- Assessment for entry to aged care being managed by the Australian Government;
- The abolition of the existing prohibition on bonds in high care residential aged care, and the freeing up of consumer contributions for those able to contribute, and the strengthen of concession safety nets for those unable to contribute to the cost of their care;
- Establish the Healthy Australia Accord;
- Explore the future creation of Medicare Select.

Medicare Select is of specific interest to Catholic Health Australia. We express formal interest in seeking to develop health plans that incorporate a specific focus on the needs of people living in socioeconomic disadvantage, so that a new priority can be given to improving access to the underserved. Indeed, improving access to the underserved must be seen as a key objective of any health reform undertaken by the Australian Government.

The report of the Commission is worthwhile. Yet it is also flawed. As a result of a combination of direction from Government and self determination, the report and its recommendations mainly ignore the role and contribution to Australia's health of the private health sector – both for-profit and not-for-profit services and ignores their current significant contribution to the health system, and the potential to build on this in the future. Currently around 50% of Australians are covered by Private Health Insurance (PHI), and many make considerable sacrifices to enjoy the benefits PHI offers. This choice and the thinking that underpins it, is not really explored by the Commission. The tacit assumption is that this choice is made because of the inadequacies of the public system, so that if they were fixed people would not be "forced" to take out PHI. This is overly simplistic and fails to recognise the attractions of the private sector around choice, efficiency of access and direct consultant involvement in care.

The Commission has not directly questioned the current management structures that actually deliver public health services. Nor has it investigated how the private sector is able to operate its
hospital services with smaller and more responsive management systems. Ignoring the role of the non-government sector to the extent that has occurred leaves the Commission’s work incomplete.

Government’s response to the Commission must not ignore the contribution of the non-government sector. Indeed, Government should look to utilise the full strength of all health care providers, and take up the offer from the non-government sector in helping to chart the future of Australia’s health and aged care services.
Introduction

This policy paper forms the response of Catholic Health Australia (CHA) to the final report of the National Health and Hospital Reform Commission (NHHRC).

The Commissioners are to be congratulated on a piece of work that is broad in scope and demonstrates a depth of issues.

The challenge is now for the Australian Government to form and finance its response to the recommendations of the Commission. This response must not just focus on hospital funding, but go further and a) ameliorate the social determinants of health that result in unnecessary hospital admissions; b) reduce regulation on aged care services that are stymieing consumer choice and c) give new recognition to palliative care so that the dignity of the dying is given a new priority in the Australian Community.

Efficiency

In aiming to strengthen the governance of health and health care the report recommends:

The Commonwealth and state and territory governments would move to new transparent and more equitable funding arrangements for public hospitals and public health care services as follows:

• The Commonwealth Government would meet 100 per cent of the efficient costs of public hospital outpatient services using an agreed casemix classification and an agreed, capped activity-based budget;

• The Commonwealth Government would pay 40 per cent of the efficient cost of care for every episode of acute care and sub-acute care for public patients admitted to a hospital or public health care facility for care, and for every attendance at a public hospital emergency department; and

• As the Commonwealth 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 per cent of the efficient cost for these services. In combination with the recommended full funding responsibility by the Commonwealth Government for primary health care and aged care, these changes would mean the Commonwealth Government would have close to total responsibility for government funding of all public health care services across the care continuum – both inside and outside hospitals. This would give the Commonwealth Government a comprehensive understanding of health care delivery across all services and a powerful incentive – as well as the capacity – to reshape funding and influence service delivery so that the balance of care for patients is effective and efficient.

The Prime Minister has committed the Federal Government to funding only ‘efficient’ health and aged care. CHA is supportive of efficient delivery of health services as long as the current access to health services is not diminished. CHA question how will the ‘efficient cost’ of services be defined. Once defined will this mean that if costs are deemed unachievable by health care providers that services will be cut?

The definition of ‘efficiency’ needs to balance cost savings with reasonable expectations that universal access to health care continues.
**Issues not considered by the Commission**

In order for sustainable reform of the national health system to occur, ‘building blocks’ or foundations for reform need to be articulated and committed to by the Australian Government.

The Commission has not provided an implementation ‘road map’ for reform, or identification of what recommendations are contingent on implementation of other recommendations. This is a weakness of the Commission’s report.

Another weakness was the decision to exclude the private health sector from the scope for the Commission’s terms of reference. The decision of the Australian Government to exclude certain aspects of the private health system from the review of the Commission has resulted in a set of recommendations that do not adequately consider the capacity and role that the private health sector plays in providing for the health of ALL Australians, including those with and without private health insurance. Evidence indicates that government policies encouraging the uptake of private health insurance lessen reliance on publicly funded health services. CHA argues there should be greater use made of the private sector in assisting to reduce public hospital waiting lists, and that this could happen immediately – a proposal that the terms of reference did not enable the Commission to properly consider.

The medical profession is largely ignored in the Commission's work, but is the most powerful determinant of patient outcomes and the cost of achieving these outcomes lie with the doctor and what they prescribe for the patient. The medical workforce, the way it is shaped (specialist versus generalist), the distribution of the workforce and the manner in which doctors are remunerated is a key aspect of how our entire health system works. There are some suggestions to implement innovative payment models to promote “bundled” care for those with chronic conditions, but a more comprehensive review of the medical profession within the system was warranted.

The Commission could also have given greater consideration to the management practices of hospitals. The Commission makes reference to a need for more clinical leadership, but the Commission has not commented on the management practices and cultures within the administration of public hospitals. There is evidence that some government operated public hospitals are burdened by having too many levels of public service management, and suffer cost inefficiencies as a result of disjointed governance structures\(^1\). In contrast, not for profit hospitals and commercial private sector management models are considered to be ‘close to the bed side’. Non-government hospital operators, be they not-for-profit or for-profit, appear to be offering more efficient hospital services and are providing greater value for money than many government operated public hospital services. The management for public hospitals vary considerably from state to state and it could be argued that the constant re-organising of management structures is not the solution to management issues within hospitals. This has happened in a number of jurisdictions and not resulted in a demonstrable improvement.

This submission below outlines CHA’s specific responses to the recommendations of the Commission. The submission requires the reader to also refer directly to the specific recommendations made by the Commission. Only those recommendations considered relevant to CHA’s mission are addressed. This mission is to provide health and aged care services to all Australians, with a preference to serve the needs of those living in socioeconomic disadvantage.

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\(^1\) Recurrent expenditure on public hospitals has increased by 64% in real terms (adjusted for inflation) over the last decade. Between 2001 and 2005, the number of hospital administrators in Australia increased by 69%. Ref: Why Public Hospitals Are Overcrowded: Ten Points for Policymakers: Jeremy Sammut: Papers in Health and Ageing (8): CIS Policy Monograph 99, 2009
CHA’s approach to responding to the recommendations of the Commission

The Commission has provided a long list of recommendations. Government should avoid the risk responding to only the ‘headline’ recommendations and deferring action on other less prominent recommendations to some later date.

To avoid this risk, it is proposed that the Government respond to all recommendations by categorizing all recommendations into two groups:

- **Category 1 Recommendations**: Reform that must be undertaken in the short to medium term in order to bring health benefits to the largest amount of people with the least amount of complex systems change, or as a precursor to other longer term reform;

- **Category 2 Recommendations**: Reform that will bring long term improvements in health and wellbeing but which require long term systems change.

CHA has categorized below the recommendations of the Commission into these two groups.

For each recommendation endorsed by Government there should be an undertaking to define the actual improvement to health and wellbeing that will flow from each proposed reform. For each recommendation not endorsed by Government, there should be an explanation as to why no action is proposed to be taken.

It is further recommended that the Government establish a new independent body to monitor the implementation of the Commission’s reform proposals, and that this new body report to both the Government and the public on reform progress. The body should oversee an implementation timetable so that sequencing of initiatives is transparent and expected Key Performance Indicators, outputs and outcomes are sufficiently monitored. The good work of the Commission must not be allowed to sit on a shelf gathering dust; a monitoring body would avoid this outcome.
Commission Report Section 1 - Taking Responsibility

CHA endorses the goal of building good health and well being into our fabric of the Australian community. The focus of the Commission’s recommendations in this regard acknowledges that long term preventive measures and health promotion initiatives do positively impact entire populations. The lead time for tangible results from these interventions (including recurrent cost savings and improved health outcomes) will often not be known for many years.

CHA would have supported greater priority in the Commission’s recommendations of the social determinants of health. The call for action to address the social determinants of health represents a single paragraph in the entire report. It deserves more attention, because it remains the case that in Australia a person’s wealth dictates their health. People of low socioeconomic status are sick more often and die earlier than people living with access to more resources. Action to address the social determinants of health by way of implementation of appropriate recommendations of the World Health Organisation’s Commission on Social Determinants of Health “Closing the gap within a generation” report should be taken as part of the Australian Government's Social Inclusion agenda.

It is also recognised that a person’s health outcomes will not change if, after treatment or commencement of a health promotion activity, they return and experience the same social determinants that have contributed to their illness in the first place. An illustrative example can be found in the common national approach to the evaluation of all health interventions recommendation where the addition of social determinants of health, where appropriate, could be included as one of the categories to be evaluated (along with medical devices, population health, and pharmaceuticals etc). In the example provided about the efficacy of various interventions to address obesity, the report does not address the relationships between geographic and contextual factors in obesity. CHA recommends that the link between social determinants and population health be further explored. Better evidence is required with regard to the effectiveness of all types of public health interventions and their role in improving population health and reducing inequalities.

Recommendations that CHA endorses for action in the short term (Category 1)

- CHA supports public reporting on health status, health service use and health outcomes by governments, private health insurers and individual service providers that identifies impacts on population groups who are likely to be disadvantaged. CHA believes the scope of this reporting could be broadened to include all government services, be they education, welfare, or income support, and should be directed to addressing the social determinants of health.

- CHA supports the setting up of a National Health Promotion and Prevention Agency, that could be tasked to act to ameliorate the social determinants of health. CHA notes that an additional $100 million has been allocated to its original proposed cost because of increases in functions. CHA would caution government to ensure that the funding of this Agency does not lead to the reduction of funds for other initiatives, that may achieve greater health outcomes more rapidly.

- CHA supports the notion that health literacy is included as a core element of the National Curriculum. To some extent this is already occurring, but better coordination with this initiative is welcomed.

- CHA supports the principle that every Australian should have a personal electronic health record that is owned and controlled by that person. It is however highly unlikely that this would occur by 2012 given that most jurisdictions have been working on the concept of e-health (of which person controlled records are one part) for the past fifteen years with little evident progress. CHA believes the Commonwealth should provide incentives to State and
Territory Governments to ensure an early outcome in establishing personal electronic records.

**Recommendations that CHA endorses for long term action (Category Two)**

- CHA supports the preventative health recommendations including the establishment of Healthy Australia Goals. The goals should be made broader than health, and include action on addressing the social determinants of health, as recommended by the World Health Organisation.

- CHA supports the recommendations relating to informal/family carers and proposes support mechanisms, including the development of educational programs and mentoring, to occur as soon as possible. The sustainability of the carers role over time will become increasingly vital as the population ages and there are less health care workers available.
Commission Report Section 2 - Connecting Care

Creating strong primary health care services for everyone

Recommendations that CHA endorses for action in the short term (Category 1)

Nil

Recommendations that CHA endorses for long term action (Category Two)

- There are significant benefits to the recommendation that the Commonwealth assume responsibility for all primary health care policy, including the proposed investment in primary health care infrastructure. CHA supports a cost benefit analysis of the establishment of the proposed Comprehensive Primary Health Care Centres (Rec # 17) against changes to existing primary care services. It is not clear whether private or not for profit providers would be eligible to provide Comprehensive Primary Health Care Centres and Services (CPHCCS) or whether these would be publicly funded entities only. Given that most GP Super Clinics are being awarded to private consortia, CHA maintains that CPHCCS should also be open to private commercial or not for profit consortia.

- CHA supports the notion of voluntary enrolment with a single primary health care provider for people with specific health needs –i.e. young families, Aboriginal and Torres Strait Islanders and people with chronic and complex conditions (Rec # 18) as a workable idea.

- The multiple funding mechanisms put forward to fund services for people with complex needs who are enrolled in a primary care service may encourage a more collaborative and multidisciplinary approach to care. Putting aside the substantial costs involved in this type of coordination, CHA supports an interdisciplinary approach to care rather than just a multidisciplinary approach. Multidisciplinary team members work sequentially where the medical record is the chief means of communication. Interdisciplinary teams on the other hand work collaboratively with regular meetings to discuss patient status and the evolving plan of care. This approach would be more likely to achieve the changes to health outcomes suggested rather than a multidisciplinary one. This approach also addresses more effectively the need to ensure optimal use of health care workforce skills, and avoids the traditional siloed approach to care delivery. CHA is supportive of the application of multiple funding streams. Government, however, must ensure that the use of multiple funding streams (ongoing fee for service payments, grant payments, outcomes payments and episodic of bundled payments) do not create perverse incentives to service providers. This recommendation requires more analysis (including cost benefits).

- There is little detail provided in relation to the development of Primary Health Care Organisations (Rec # 21). CHA is supportive of the concept, but the Commission report does not provide sufficient information in order for detailed comment to be made. The planning areas for these organisations are approximately 250,000 to 500,000 people. CHA proposes that planning boundaries align with other important health related groupings, such as Health Workforce Australia’s proposed clinical placements ‘communities of interest’. In this way clinical training and workforce demand would be aligned.

Nurturing a healthy start

The evidence base for early childhood intervention is well established. CHA is broadly supportive of the recommendations in this regard.

Recommendations that CHA endorses for action in the short term (Category 1)
• CHA supports the immediate introduction of early childhood intervention, as described (Rec # 24). Immediate moves could be made to ensure that there is nationally consistent provision of early childhood support and the development of an evidence based schedule of core contacts from birth to eight years should not be cost prohibitive and will be able to be applied within existing services and infrastructure (child and maternal health centres, GPs, community health etc).

• CHA supports the immediate introduction of the role of school nurse in primary school, who will monitor health and well being of children attending that school (Rec # 25). This would be one of the most effective and efficient ways to promote and monitor children’s health nationally. CHA notes that this recommendation was not costed in the final report.

**Recommendations that CHA endorses for long term action (Category Two)**

• Identification of children with particular health or developmental issues in order to be eligible for an enhanced package of care will take some time to implement and will be dependent upon the successful implementation of the primary health care recommendations. CHA however supports the adoption of this recommendation (Rec # 24) and has itself advocated for the creation of care coordinators able to access funds in order to create packages of services for children and families.

**Ensuring timely access and safe care in hospitals**

CHA endorses the principle of developing National Access Guarantees. CHA has previously advocated for a similar initiative when it proposed the establishment of a national Health Access Ombudsman to be tasked with monitoring access to public health services.

There are however many issues that need to be considered before Australia will be able to effectively establish a set of national access targets. If you take for example the differences between government public, non-government public, for-profit private and not-for-profit private hospitals, it is currently impossible to accurately compare hospital costs and efficiencies of their operations in the absence of consistent data to be able to do so. Effort should be expended in development of robust data sets needed to identify the underlying reasons for differences in hospital efficiency – whether this be because of management structures, different funding mechanisms or simply the inherent inefficiencies that come with having large health bureaucracies.

The National Access Targets as proposed do not take account of these differences. CHA also has serious doubts that valid comparisons could currently be made across different jurisdictions within the public sector - let alone between the public and private sectors. That said, these barriers in time can be overcome, and CHA endorses the transparent insight and patient benefits that would arise from new competition between health services that the National Access Targets would stimulate.

There are also differences between public and private sector “products”. The private product is distinct from the public product in the sense that patients who elect to receive private treatment have already made a full, compulsory contribution to the public hospital system through their taxes as part of the universal Medicare coverage. This means that patients need to be convinced to spend additional money in order to receive private treatment. There are a range of reasons people may choose to do this, including:

• Having a choice of provider (doctor and/or hospital),
• Faster access to treatment, and
• The opportunity to choose treatment in a setting that meets the patient’s pastoral or personal requirements at a time of illness and vulnerability.
The private hospital sector is providing an increasing proportion of total hospital services in many different specialty groups, particularly in the areas of Cardiac Medical, Cardiac Interventional, Oncology, Obstetrics, Orthopaedics and Gastroenterology. It is important for the future of Australia's health system to create robust, consistent, national datasets that allow comparisons between health sectors. More work is required to set up nationally consistent data sets across the spectrum of health, prior to the introduction of National Access Targets. Only then can truly valid comparisons be made.

Once consistent data sets have been established, more detailed reporting could and should be undertaken. The Medicare USA website where members of the public can find and compare hospitals and nursing homes in their areas, is the type of reporting that Australia could be working towards (see http://www.medicare.gov/ and scroll down to "Compare Nursing Homes in Your Area" or "Compare Hospitals in Your Area"). This type of consumer information enables greater choice, and the competitive tensions between service providers that arise from the publication of comparable data has been shown to drive improvement in the overall quality of service delivery.

There is little merit in paying bonuses to health services that meet the prescribed targets. Such an approach is likely to drive a perverse set of incentives for service providers to pursue bonuses. The experiences of the ACHS Equip Accreditation model and the ACHS Clinical Indicator program indicate that underperforming organisations or agencies will find it easier to meet access targets if they are supported to do so. It is also proven that there may be many reasons organisations fail to meet access targets - acuity, geographical locations, and workforce issues. It may be more reasonable to develop a range rather than a definitive target that hospitals should be encouraged to comply with. A range can take into account other factors that influence performance (as mentioned above) as well as providing incentives to improve. That said, rewards (not necessarily monetary) should be provided to organisations that achieve good performance in outcomes and timeliness of care.

Recommends that CHA endorses for action in the short term (Category 1)

- Data exists enabling some of the National Access Targets (Rec # 27) to be reported on now, such as the planned surgery metrics, emergency departments and radiotherapy measures. Others will need to be developed. Part of the problem with reporting some of the hospital related targets is that ability to meet targets may not be due to poor performance, but rather due to the non availability of inpatient beds and seasonal variations (with the Swine Flu pandemic an instructional example). Participating health services should only be required to report specific sets of data to one place – not to several places in duplication.

- CHA supports the implementation of nationally consistent activity based funding (Rec #30), but notes the annual savings proposed to be made from this measure are based on an assumption that higher average costs per episode in some States will be decreased to the average cost. Tasmania, the Northern Territory, the Australian Capital Territory and Western Australia are States or Territories who currently have a higher than national average cost per procedure. It may not be possible to reduce these costs (particularly in the smaller health systems) because of scale, geographical, and workforce issues.

- The Productivity Commission is currently assessing the cost efficiencies of public and private hospitals. It is doing so without access to a reliable data set that allows a workable comparison of hospital costs. A long term initiative should be established to identify how the costing comparisons across the private and public hospital sectors should be undertaken, what datasets would be required, and what resources would be needed to undertake a long term detailed study that would result in reliable outcomes. Given that the National Hospital

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Cost Data Collection (NHCDC) in particular was not set up with the objective of comparing public costs against private, there are serious issues related to the available data in terms of quality, representativeness and consistency of definition. This requires addressing prior to implementation of this recommendation and Recommendation # 34.

- Emergency department services should be funded on an activity basis as well as fixed grants. Activity based payments should include a cost for the provision of capital.

- An Office of Hospital Cost Data should be established within the current Commonwealth Department of Health and Ageing, with responsibility to oversee the creation of a national robust and consistent hospital cost data set to collect information from all public and private hospitals across the nation. The new office should be supported by an external board of governance comprising representatives from public and private health sectors.

- An independent data audit agency should be established, with a mandate to audit cost and quality data submitted by all private and public hospitals.

- In relation to quality improvement (Rec#32) and the development of safety and quality data, as distinct from funding issues, there are datasets that are currently collected by bodies such as the Australian Council on Healthcare Standards whose data collections are useful - although limited in scope by their voluntary nature. There are also data sets collected in a number of the States (especially in Queensland and Western Australia) that would allow comparisons to be made across the public and private sectors. The mandatory nature of the collections in these States provides a strong basis for appropriate cross-sectoral comparisons. The Australian Commission on Safety and Quality in Health Care is well placed to provide guidance in this regard, as indicated in Appendix G. In this regard it should be noted that the Australian Private Hospitals Association does not represent the interests of all Catholic hospital facilities, so that if a new data collection process is to be created, CHA would seek to be included as part of the group tasked with progressing this recommendation (see Appendix G, p.211).

- CHA supports the development of clinical leadership within hospitals (Rec#36), but argues against such an initiative being pursued at a national level. Effective management and leadership within hospitals should occur at the local level.

**Recommendations that CHA endorses for long term action (Category Two)**

- Greater delineation of hospital roles should be pursued, most notably the separation of planned and emergency admissions. Public and private Catholic health care institutions have long been integral to the provision of health, aged and community care services in Australia and collaboration between these providers has increased in recent years in an effort to use limited resources more effectively. In addition to the splitting of emergency care from elective care there could be greater provision of public care in the not-for-profit sector. Changes to roles and functions of hospitals may take time, such as greater allowance for elective surgery to occur in private and not-for-profit hospitals, as successfully demonstrated by the Surgery Connect program funded by Queensland Health and managed by the Mater Hospital Brisbane. Care needs to be taken if elective and emergency services are separated that public hospitals retain the capacity to provide 24 hour emergency surgery coverage.

- CHA support provide to the proposal to expand bed capacity in public hospitals with major emergency departments so that they are able to operate at 85% capacity.

**Restoring people to better health and independent living**

CHA endorses all recommendations within this section, and actually called for the introduction of a sub acute system in earlier submissions to the Commission. As well as the provision of sub
acute rehabilitation, services could also provide clinical placement opportunities for undergraduate and post graduate health sciences professions such as medicine, nursing and allied health.

**Increasing choice in aged care**

CHA strongly endorses the reform directions encompassed in the aged care recommendations, and notes that several of the Commission’s recommendations mirror the contents of CHA’s Aged Care Policy Blueprint, which was released to Government in November 2008.

Australia’s current aged care system will not be viable into the future. Current regulation prohibits providers from having access to sufficient funds to recover the cost of providing aged care accommodation. If change does not occur, at some point in the near future there will not be enough residential aged care services to meet demand, and it will be people of low socioeconomic status who will be hit the hardest by this shortfall.

Similarly, current regulation prohibits consumers from having choice in how to access their services. The Productivity Commission has found that current regulation is in fact adversely impacting the care that older Australian’s receive. The case for reform is overwhelming.

CHA notes that implementation of the Commission’s recommendations would result in greater consumer choice, more responsive services to meet the needs of older people and their families, access to affordable services for those without adequate means to contribute to the cost of their aged care, and most importantly help create an environment which would sustain a viable aged care sector into the future.

**Recommendations that CHA endorses for action in the short term (Category 1)**

- Subsidies should be linked to care recipients rather than places (Rec # 42). This is a prerequisite to introducing greater consumer choice in accessing aged care services, including choice of provider and the setting (residential, community or respite) in which care and support are received. Transitioning from a provision ratio based on places per 1000 people aged 70 and over to care recipients per 1000 aged 85 and over would significantly increase the availability of Commonwealth subsidised aged care services. However, this approach would continue the current policy of rationing services and would not necessarily ensure care for all who are assessed as needing care. Although this measure would be a significant improvement on the current formula for rationing services, CHA instead proposes a universal entitlement to aged care system whereby all people assessed as being in need of care receive an entitlement for care. Concerns about the fiscal risk to the Commonwealth can be managed through a reform of the ACATs so that they can fairly and consistently perform the role of ‘gate keepers’ for care entitlements.

- The Commission’s recommendation (Rec # 46) that responsibility for ACATs be transferred to the Commonwealth provides the opportunity to transform the ACATs into an independent national network of Access and Information Centres which would provide consistent and timely assessments, manage the Commonwealth’s risk by ensuring that only those who need care receive an entitlement, and provide information and support to care recipients in choosing care options. CHA outlined such a proposal to the Commonwealth Government in January of 2009.

- CHA considers that care recipients requiring residential high or low care should have flexibility to choose how they make their accommodation payment, including a fully refundable lump sum payment, rent, a combination of these, or as a deferred payment in the form of a charge on the resident’s estate (Rec # 43). This flexibility should also extend to any care payments that the care recipient may be required to make. Such flexibility would allow each care recipient to choose a payment method that best suits their personal and financial
circumstances, including implications for pension entitlements. CHA agrees that flexibility in accommodation payments should be introduced in conjunction with the deregulation of the supply of places (services) and greater consumer choice of care provider and setting, resulting in increased competition in supply and prices. CHA considers, however, that this measure of itself would not address the shortfall in capital in high care identified in the Economic Evaluation of High Care Capital undertaken by Access Economics and at the same time ensure access for those with fewer means. This measure would need to be complemented by a commensurate increase in the accommodation supplement paid by the Commonwealth for those unable to meet the cost of their accommodation.

• CHA agrees that better informed consumers are a prerequisite to the effective exercise of choice and for fostering competition (Rec # 44). CHA considers that there will need to be careful consultation with stakeholders over the selection of a suite of quality indicators to ensure that they are meaningful and are collected in the normal course of effective service delivery. Caution is also required to give consideration to variable factors such as geography, socioeconomic status of residents, and the availability of workforce. It is noted that reforming the ACATs into a network of Access and Information Centres (Rec # 46) would also be an effective mechanism for informing consumers.

• CHA strongly endorses the proposed consolidation of aged care policy and funding under the Commonwealth Government, including the proposal to make HACC a direct Commonwealth program (Rec # 45). This is essential to enable effective policy integration around consumer choice and access, assessment and eligibility, subsidy and fee policies and accountability and quality assurance arrangements across the continuum of aged care services. It is also a prerequisite for moving away from the current fragmented arrangements, especially in community care, which are unfair and confusing for care recipients and their families, and add to administrative costs for providers.

• CHA endorses the development and introduction of streamlined, consistent assessment for eligibility for care across all aged care programs as one of the reforms needed to ensure consumer choice of quality aged care services (Rec # 46). As indicated in relation to Recommendation 42 above, reformed ACATs, whereby they would become a national network of Access and Information Centres, would provide a good vehicle for administering the streamlined arrangements.

• CHA strongly agrees with the recommendation to introduce a more flexible range of aged care subsidies for people receiving community care compatible with care subsidies in residential care (Rec # 47). This is a prerequisite for allowing fair consumer choice of care setting, including the option to continue to receive care in the community as care needs change.

• CHA agrees that, subject to the provision of sufficient funds for staff training and remuneration, all aged care providers (community and residential) should be required to have staff trained in supporting care recipients to complete advance care plans for those who wish to do so (Rec # 51). Such a system needs careful management, to ensure that care recipients understand they are not required to complete advance care plans and may instead voluntarily chose to do so if they so elect.

• CHA agrees with the recommendation that people who can contribute to the costs of their own care should contribute the same for care in the community as they would for residential care (not including accommodation costs) as a basis for facilitating consumer choice.

• People who choose to receive their care in the community should also have the option to determine how the resources allocated for their care and support are used, including choice of provider (Recs # 48,49).
• CHA agrees that older people should have greater scope to choose themselves between using their entitlement for community or residential care, and agrees that a five year transition plan is required to enable service providers to adjust to a regime of greater choice in order to ensure continuity of care given the potential for a significant change in the balance of services types (especially when implemented in conjunction with a deregulation of the supply of places) (Rec # 50). CHA considers that it is essential that the transition arrangements are developed in consultation with stakeholders, and that they are transparent with clear milestones and timeframes. CHA strongly supports the periodic review of the cost of care to ensure that care subsidies are sufficient to allow the delivery of quality care, and that such periodic reviews of care costs should encompass the full spectrum of care recipients in residential care not just the most frail aged.

Recommendations that CHA endorses for long term action (Category Two)

• Funding should be provided for use by residential aged care providers to make arrangements with primary health care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes (Rec # 52). Subject to the details of the arrangements being developed in consultation with stakeholders and clinical responsibility remaining with the clinicians involved, CHA notes however, that the proposal will be of limited value in regions where there are shortages of relevant skilled professional clinicians and/or if the sessional rates are not financially attractive.

• CHA agrees that the safety, efficiency and effectiveness of care of older people in residential or community care can be assisted by better and innovative use of technology and supports the specific recommendations (Rec # 53). CHA notes, however, that many of the measures require upfront capital investment and staff training costs which are not comprehended in the existing funding arrangements. Accordingly, CHA considers that there should be financial incentives provided to help meet the upfront costs of adopting new technology.

Caring for people at the end of life

The Commission has demonstrated a strong appreciation of the need to deliver care that has a focus on quality and not solely quantity of life.

Recommendations that CHA endorses for action in the short term (Category 1)

Nil

Recommendations that CHA endorses for long term action (Category Two)

• CHA supports the notion of building the capacity and competence of primary health care services to provide generalist palliative care support for their dying patients (Rec # 54). The greater educational support and improved collaboration and networking will need to be supported by government and has not been costed by the Commission. Palliative Care Australia is well placed, with additional funding, to facilitate this process.

• Specialist palliative care services should be accessed by those who need them, regardless of setting (Rec # 55, 56). More specialist training positions should be made available and these positions require funding. Greater clarity for the general health worker of when specialist palliative care services are required and when general palliative care services are needed should also be provided. The role of the specialist palliative care service is not only in service delivery, but in education of generalist palliative care employers and other health professions and community.
CHA welcomes the recommendation that advance care planning be funded and implemented nationally, commencing with all residential aged care services (Rec # 57). It is important to recognise that palliative care occurs across all spectrums, and advance care planning should be introduced to all settings. This is a big undertaking and as indicated initial costs will be high to educate necessary staff.

**Closing the health gap for Aboriginal and Torres Strait Islander peoples**

Aboriginal and Torres Strait Islander health status is unlikely to improve significantly in the absence of an improvement in the underlying social and economic conditions. Significant emphasis therefore needs to be placed on improving access to services such as education, employment and housing.

CHA endorses each of the proposals of the Commission in relation to Indigenous health.

**Delivering better health outcomes for remote and rural communities**

CHA endorses the Commission’s recommendations made in relation to rural and remote communities. CHA provides two additional observations.

The role of non-government providers in rural and remote communities was not acknowledged in the final report. Sometimes regional private and not-for-profit services are not viable (for reasons stated in the final report) and unless they are supported by government, consumers will have diminished access to services.

The second observation is that technological changes are enabling new ways of providing services in rural and regional areas. Infrastructure to utilise these technologies are in place for the public providers. Regional private providers are very often not able to access capital or equipment funding in sufficient quantities to enable them to consistently provide telehealth services in some regional, rural, and remote areas. Telehealth and affordable web based services are also important in the provision of mental health services to rural and regional populations.

The Commission’s report did not adequately address this issue of sustainability of private and non-government service providers in rural, regional and remote areas.

**Supporting people living with mental illness**

CHA supports the recommendations relating to supporting people living with mental illness, but notes that the workforce implications in implementing these recommendations require further analysis.

**Improving oral health and access to dental care**

CHA is supportive of the proposal to establish Denticare and strongly support Denticare to provide universal access to basic dental services. There is however a need to reshape MBS to shift from a purely fee for service funding model to a blend of funding models including outcome and episodic payments. In addition CHA believe there needs to be greater definition given to restorative care, that is, it needs to include not just fillings but root canal work and crowns etc, which it currently excludes.
Commission Report Section 3 - Strengthening the governance of health and health care

Healthy Australia Accord

It is time for Australia to cease the practice of describing and utilising hospitals according to their funding mechanism. The divide between public and private hospitals is increasingly becoming an ideological driven division. Instead of emphasising the differences between the two systems, it is time to refer to all hospitals, be they publicly or privately funded, as simply hospitals. If we mature as a nation to see the public and private hospitals as simply a single system of health care organisations, it will allow for increasingly scare resources to be better used for improved patient outcomes.

The public and private hospital sectors (including the not-for-profit as well as the for-profit sectors) need to work more constructively in partnership with primary and community care providers to meet the expectations Australians have of their health care system. The Moving towards ‘one health system’ section (6.4.1) does not mention the private health sector. Nowhere in the report is there a discussion of how the private sector will contribute to the reform process.

The omission of any detailed discussion about the current make up and capacity of the private sector suggests the Commission’s proposal to create ‘one health system’ has not been properly thought through.

The report of the Commission should have included discussion of the significant contribution of the private sector to Australia’s total health care system:

- 40% of hospital separations (3.1 million out of 7.9 million in total) occur in the private sector;
- In the last year public patient separations increased by 1.9%, private patient separations increased by 5.4%, and separations for private patients funded by private health insurance increased by 6.7%;
- Between 1998–99 and 2007–08, private hospital separations increased by 37.3%.
- Separations increased by 23.1% in public acute hospitals and by 66.9% in private hospitals (including freestanding day hospital facilities).
- Separations per 1,000 persons increased by 5.2% for public acute hospitals and by 39.6% for private hospitals.

These statistics indicate that private hospitals have reduced the workload on public hospitals. With current Government policy seeking to reduce incentives to health consumers to hold private health insurance, it should be noted that any reductions in private health insurance membership will likely have adverse impacts on the public health system. Given that over the 6 years from 2001-02 to 2006-08 public hospital waiting times have increased by 25% from 27 days to 34 days, any new pressure on public hospitals should be avoided.

Noting that Government needs to give new consideration to the role of the private health care providers as part of the national health system, CHA endorses the proposed directions of the Healthy Australia Accord, but with the following reservations:

- The Commission proposes that “The Commonwealth and State and Territory Governments would move to new transparent and more equitable funding arrangements for public hospitals and public health care services as follows (Rec #88.2). In response to this recommendation:
  - No explanation has been provided as to how ‘efficient’ costs will be derived, i.e. what methodology will be used to calculate cost.
  - New data sets are likely to be needed to properly inform what ‘efficient’ costs are.
• CHA fully supports the creation of a single tier of government having responsibility for funding, policy and taking accountability for the performance monitoring of the public health system.

• CHA proposes the establishment of a body to undertake further work on reform of governance arrangements with a realistic timeframe for proposing more substantial reform of the health architecture. The undertaking of further work on future governance arrangements should not detract from the imperative to move quickly to implement the Commission’s other recommendations, which will have an immediate impact on improving access to health services.

• The Commission proposes “The Commonwealth Government would pay 100 per cent of the efficient cost of delivering clinical education and training for health professionals across all health service settings, to agreed target levels for each state and territory (Rec # 88.3). In response to this recommendation States, Territories and the Australian Governments must come to a compromise quickly with regard to how Health Workforce Australia (HWA) will operate. The Commission’s report does not mention HWA explicitly and recommends a National Clinical Placement Agency. The legislation to establish HWA was passed in June 2009. The allocation of the substantial COAG funding for clinical training and health workforce planning has not yet been endorsed by Health Ministers. This must happen as a matter of urgency and the work of HWA commenced.

**Medicare Select (Recs # 89 – 90.13)**

CHA supports exploration of the proposed Medicare Select. In the event that Government accepts the recommendation to establish a working party to further advance this recommendation of the Commission, CHA expresses its interest in contributing to this policy development.

CHA has identified an opportunity for the Catholic Church under Medicare Select to fulfil its mission in healthcare by potentially establishing and operating health and hospital plans for people living in socioeconomic disadvantage. Given that people in socioeconomic disadvantage are have the high levels of ill health and short life expectancy when compared to other socioeconomic groups, CHA has commenced work in exploring how a health plan which would also include coverage for people living in socioeconomic disadvantage.

There are however several weaknesses in the proposed Medicare Select – the proposed model assumes that competing funds would exist and that there would be a choice from a range of service providers – which clearly is not the case in all regions today and is unlikely to be so in the future. The Commission’s recommendations do not address this issue of ‘market failure to provide’ in regional, rural, and remote areas adequately. Alternative arrangements would need to be provided for in areas where there is no competition in the health care market.

The model also assumes a level of sophistication on the part of consumers to be able to select a health fund. Not all consumers will be readily able to exercise this new power. Any reform in this direction will need to be supported by measures to improve consumer knowledge and information, most notably for people living in socioeconomic disadvantage.

As indicated in the report, the Commission recommends that a two year period be taken by Government to consider the implementation of this recommendation. CHA expresses an interest in participating in any formal process that might be established to undertake a review of the merits of Medicare Select.
Commission Report Section 4 - Raising and spending money for health services

CHA endorses the Commission’s recommendation that the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution be maintained over the next decade (Rec # 92).

There is evidence to prioritise the Commission’s recommendation to grant additional capital investment in the areas of Comprehensive Primary Health Care Centres and Services; expansion of sub-acute services including both inpatient and community-based services; investments to support expansion of clinical education across clinical service settings; and targeted investments in public hospitals to support reshaping of roles and functions, clinical process redesign and a reorientation towards community-based care (Rec # 97). CHA proposes that non-government services be able to access any specific funding that might be made available in this regard.

Working for us: a sustainable health workforce for the future

Many of the Commission’s workforce recommendations have already been implemented or are in the process of being implemented. The Commission recommend the establishment of a National Clinical Education and Training Agency (Rec # 101). As stated above Health Workforce Australia already has this remit. CHA is, however, supportive of the Commission’s findings in relations to the future of the health workforce.

Fostering continuous learning in our health system

CHA welcomes the recommendation to increase the availability of part-time clinical research fellowships across all health sectors to ensure protected time for research (Rec # 105) and infrastructure funding for research is welcome. It should be accessible to both the public and private sectors (Rec # 107).

CHA strongly supports the recommendation that the Australian Commission for Safety and Quality in Health Care should be established as a permanent, independent national body (Rec # 111).

Implementing a national e-health system

CHA provides in principle support to the recommendation of the Commission that the Commonwealth Government mandate payment of public and private benefits for all health and aged care services to be dependent on the ability to accept and provide data to patients, their authorised carers, and their authorised health providers, in a format that can be integrated into a personal electronic health record (Rec # 120). Financial assistance and incentives will be required to help defray the cost of implementing the systems required.