Catholic Health Australia

Strategic Plan Background Paper 2009

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1. Introduction

The Catholic Health Australia (CHA) Strategic Plan 2009-2011 needs to focus on and balance both Catholic identity issues and immediate public policy concerns.

This Background Paper provides an initial assessment of the current status and key issues for CHA in Australia. It also helps guide relevant and informed content for the Strategic Plan 2009 - 2011. The focus for the strategic plan is the CHA organisation itself and what directions the organisation should move in over the next three years. The CHA strategic plan must protect the interests of CHA, its members and set clear objectives and strategies. By necessity reference is made to the wider environment, particularly the political, social and economic pressures and priorities that characterise the health and Catholic environment. Understanding these environments allows identification of the most effective mechanisms for ensuring broad ownership of future strategic directions.

Environmental scanning assesses the internal strengths and weaknesses of an organisation in relation to the external opportunities and threats it faces. Typical focal points for the scan are competition, technology, regulatory activity and the economy.

The issues relevant to CHA are categorised across four different areas:

1. Catholic Health Australia's foundational principles
2. Strategic context for CHA
3. Australia's health policy context
4. Aggiornamento (Renewal)

The paper will conclude with seven critical issues facing CHA and its members in 2009 -2011.

Catholic Health Australia's foundational principles

The Catholic health sector forms the largest non government grouping of health, community and aged care services in Australia. It is a significant part of Australia's health system and plays a critical role in Australia's overall health care industry, accounting for around 9,500 beds across 75 health care facilities - 21 publicly and 54 privately funded hospitals, including 7 teaching hospitals and 8 dedicated hospices and palliative care facilities. Together, the sector cares for around 13 per cent of all patients admitted to hospitals in Australia and employs over 35,000 people.

Catholic Health Australia exists to promote and strengthen the organised expression of the Catholic health ministry. The healing ministry of Christ is an integral part of the Church's mission. In Australia, Catholic health care has a rich tradition of more than 160 years of commitment and service provision to the Australian community.

The sector comprises providers of the highest quality care in the network of services, ranging from acute care to community-based services. These services have been developed in response to community needs. The services return the benefits derived from their businesses to their services and to the community; they do not operate for profit and are church and charitable organisations. The sector also plays a significant role in rural and regional Australia.

The Catholic health ministry is broad one. Services cover aged care, disability services, family services, paediatric, children and youth services, mental health services, palliative care, alcohol and drug services, veterans' health, primary care, acute care, non acute care, step down transitional care, rehabilitation, diagnostics, preventive public health, medical and bioethics research institutes.

Catholic Health Australia Incorporated is an association incorporated in the Australian Capital Territory under the *Associations Incorporation Act*

1991. When engaging public policy concerns, Catholic Health Australia will base its advocacy and policy development on the following foundational principles:

Dignity of the Human Person

Each person has an intrinsic value and dignity. Within the context of health care in Australia, this means everyone has a right to essential, comprehensive health care. This should be reflected in the manner through which a person is cared for along the continuum of his or her life. At all times the respect for human life is considered paramount to any policy or operational decisions. Catholic health contends that the inalienable dignity of the human person should be upheld in all his or her dimensions; physical, psychological, emotional and spiritual. Catholic health services seek to reflect these dimensions and attempt to witness their value to the community at large.

Service

The provision of health care is conducted out of a spirit of service and solidarity with those in need. Health care is a social good. The degree to which health care is driven by a genuine compassionate concern for others and a selfless commitment to the well being of people, will be the measure by which a community can gauge its maturity and sense of integrity. Catholic health care's mission is intricately related to this notion of service and to the respect for the sacredness of every human life. Health care is not a mere commodity open to entrepreneurial manipulation or the result of commercial profit making. Catholic health seeks to re-invest continually in the pursuit of quality health standards, outcomes and patient care.

Common Good

Our commitment to the dignity of every individual leads us to an appreciation and dedication to the community at large. Catholic health is an active partner in the ongoing development of the health care of the community. It seeks to expand access to care, commit resources to research and training and conduct on-going professional inquiry into the social, ethical and cultural aspects of health care. Within the broader social context, the health needs of individuals must be balanced by those of the community.

Preference for the Poor and Under-Served

Catholic social teaching has embraced a 'preferential option for the poor'. This stresses our concern for the provision of adequate, timely health care for all, especially those who have little choice, opportunity or capacity to pay. Across the acute, aged care and community sector, the well and wealthy should care for the sick and poor.

Structural reforms need to identify 'poverty gaps' in the system and move to eradicate areas which leave people vulnerable and isolated from care. Broader economic reforms must enable all people to receive dignified care at all times.

Stewardship of Resources

Creation and human life are divine gifts. We are called to treat them responsibly and to manage them wisely. Health resources must likewise be prudently developed, maintained and shared in the interests of all. Economic discipline and realistic control on expenditure characterise sound health management. Resources for health care must be balanced alongside those needed for other essential human services.

Subsidiarity

The needs of individuals and communities are best understood and satisfied by those closest to them within a spirit of solidarity and service. Applied to health this has implications for the extent of choice and the devolution of responsibility that exists within a system. Where at all possible, individual autonomy and the freedom to determine one's mode of health care need to be encouraged. The administration of health care is most suitably conducted closest to those being served.

According to the Association Rules, CHA:

- Takes a leadership role in supporting and strengthening its membership to develop individually and collaboratively to ensure the healing ministry flourishes as an integral part of the mission of the Catholic Church,
- Promotes a just system of health and aged care delivery that has at its heart an imperative for those who are poor and marginalised, and
- Is the unified public voice for the members on matters of common interest.

CHA must also:

- Promote and proclaim Catholic identity as an integral part of the vision, passing it into the next generation of leaders,
- Educate through the formation of leaders of Catholic health and aged care in the healing ministry of Jesus Christ and in matters of Catholic social teaching, ethics and justice in health and aged care, and
- Renew and inform through:
    - Research as the basis of advocacy and communication both within and outside the sector,
    - Advocacy as a means of promoting and proclaiming the Catholic tradition and ethos in health and aged care, and
    - Communicate to the members relevant matters of significance.

Results of the Strategic Plan Survey reveal that the Association Rules appear to serve CHA well. The makeup of the Stewardship Board must be balanced and give voice to all member organisations.

If associate or individual membership is adopted then the by-laws will need to change to reflect this.

In the Strategic Plan survey results there were some comments to the effect that the Association rules may be 'tired' or dated, and reflect the environment of the time in which they were written.

Will the current Association Rules serve CHA well, in the future?

2. Australia's health policy context

It is generally recognised that Australians enjoy good health and one of the longest lifespans in the world, with outcomes expected to continue to improve, according to the Australian Institute of Health and Welfare (AIHW, 2008a). This is not the case for Indigenous Australians. However, overall Australia does compare well with other countries from the OECD. In the three areas assessed by the OECD in 2005, Australia performed well in the league of 30 OECD countries.

Australia has the best performance from its public health expenditure of any OECD country, and the fourth highest performance from its total health expenditure (behind Japan, Spain and New Zealand). Possible explanations for this finding are:

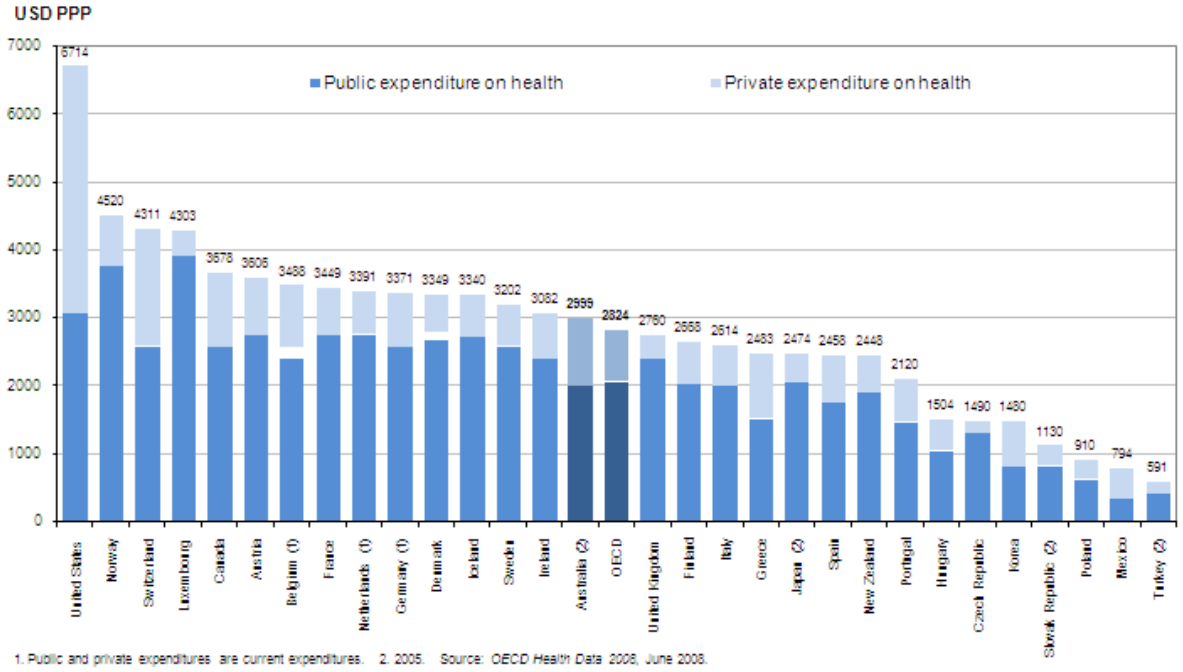
- High GDP per capita and fairly young population structure,
- 70% of Australian's population live in urban areas,
- Australia has different clinical models of care, practice preferences and indemnity environments,
- Reliance on evidence-based care as well as use of cost effectiveness analysis, and
- Prevention, early detection and intervention (including through pathology and diagnostic imaging services) are utilised extensively[1].

According to ***OECD Health Data 2008*** **- How Does Australia Compare** [2] Australia's health data shows that:

- Total health spending accounted for 8.8% of GDP in Australia in 2005, slightly lower than the average of 8.9% in OECD countries in 2006,
- Health spending as a share of GDP is lower in Australia than in the United States (which spent 15.3% of its GDP on health in 2006) and in a number of European countries including Switzerland (11.3%), France (11.1%) and Germany (10.6%),
- Australia ranks above the OECD average in terms of total health spending per capita, with spending of 2999 USD in 2005 (adjusted for purchasing power parity), compared with an OECD average of 2824 USD,
- Health spending per capita in Australia remains nonetheless much lower than in the United States (which spent 6714 USD per capita in 2006) and in Norway, Switzerland and Luxembourg,

[1] Health expenditure and outcomes, Report by Access Economics Pty Limited for The Australian Association of Pathology Practices Access Economics, January 2009

[2] http://www.oecd.org/topicdocumentlist/0,3448,en_33873108_33873229_1_1_1_1_37407,00.html accessed 1/4/09



Data are expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are

The rates of currency conversion that equalise the cost of a given 'basket' of goods and services in different countries.

- In Australia, 67% of health spending was funded by public sources in 2005, below the average of 73% in OECD countries,
- Despite the relatively high level of health expenditure in Australia, there are fewer physicians per capita than in most other OECD countries. In 2005, Australia had 2.8 practising physicians per 1 000 population, below the OECD average of 3.1. There were 9.7 nurses per 1 000 population in Australia in 2005, a similar figure to the average in OECD countries,
- The number of acute care hospital beds in Australia was 3.5 per 1 000 population in 2005, slightly below the OECD average of 3.9 beds per 1 000 population,
- As in most OECD countries, the number of hospital beds per capita in Australia has fallen over time. This decline has coincided with a reduction of average length of stays in hospitals and an increase in the number of surgical procedures performed on a same-day (or ambulatory) basis,
- During the past decade or so, there has been rapid growth in the availability of diagnostic technologies such as computed tomography (CT) scanners and magnetic resonance imaging (MRI) units in most OECD countries. In Australia, the number of MRIs has increased from 0.6 per million population in 1990 to 4.9 in 2006, although these include machines eligible for Medicare reimbursement only. The OECD average was 10.2 MRI units per million population in 2006,
- In 2006, life expectancy at birth in Australia stood at 81.1 years, more than two years higher than the OECD average. Australia has the fourth highest life expectancy among OECD countries, following Japan, Switzerland and Iceland, and
- The infant mortality rate in Australia, as in other OECD countries, has fallen greatly over the past decades. It stood at 4.7 deaths per 1 000 live births in 2006, lower than the OECD average of 5.2.

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National Health & Hospitals Reform Commission

Many of the big questions in the health and aged care sectors will not be answered until government responds to a number of strategic reviews, due over the next couple of months

The National Health & Hospitals Reform Commission is one of these reviews. The National Health and Hospitals Reform Commission was appointed in February 2008. The Commission's terms of reference clearly highlight the context for reform.

The Commission's first term of reference was to provide, by April 2008, advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care. This was the subject of the Commission's first report - Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements.

The Commission has also developed a set of principles which to a large extent should shape the whole health and aged care system - public and private, hospital and community based services. These principles describe what the health and aged care system should encompass:

- People and family centred
- Equity
- Shared responsibility
- Strengthening prevention and wellness
- Comprehensive
- Value for money
- Providing for future generations
- Recognise broader environmental influences which shape our health
- Taking the long term view
- Safety and quality
- Transparency and accountability
- Public voice
- A respectful and ethical system
- Responsible spending on health, and
- A culture of reflective improvement and innovation

The Commission has prepared an Interim Report – A Healthier Future for All Australians – which contains its proposed reform directions. The Commission has identified four themes which encapsulate its directions for reform:

- Taking responsibility: individual and collective action to build good health and wellbeing – by people, families, communities, health professionals, employers and governments,
- Connecting care: comprehensive care for people over their lifetime,
- Facing inequities: recognise and tackle the causes and impacts of health inequities, and
- Driving quality performance: better use of people, resources, and evolving knowledge.

Key proposals from the Commission can be found at **Appendix 1**.

Of particular interest to the Catholic health and aged care sector are the proposed three major possible approaches to improving governance of the Australian health system.

The three models are:

Option A – continued shared responsibility between governments, with clearer accountability and greater Commonwealth responsibility for some functions.

Option B – Commonwealth to have sole responsibility for all aspects of health care, with delivery through regional health authorities.

Option C – Commonwealth to have sole responsibility for all aspects of health care, with establishment of compulsory social insurance to fund local delivery of health services.

Option A – continued shared responsibility between governments, with clearer accountability and more direct Commonwealth involvement

This option would retain both Commonwealth and state and territory involvement but re-align responsibilities between them, with the Commonwealth:

- becoming responsible for all funding, policy and regulation for primary health care and community health services, including those currently funded by states;
- paying to states and territories a substantial hospital benefit per episode of the efficient costs of inpatient treatment and of emergency department treatment (set at, say, 40 per cent); and
- paying, using a casemix classification, 100 per cent of the efficient costs of delivery of hospital outpatient treatments.

Option B – Commonwealth solely responsible, with regional providers of some services

The second option canvassed is a transfer of all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing and funding regional health authorities to take responsibility for former state health services such as public hospitals and community health services, in parallel to continued national programs of medical and pharmaceutical benefits and aged care subsidies.

Option C – Commonwealth solely responsible, with competing health plans responsible for providing cover for most services

The third option canvassed is to transfer all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing a tax-funded community insurance scheme under which people would choose from multiple, competing health plans. These plans would be required to cover a mandatory set of services including, for example, hospital, medical, pharmaceutical and allied health services.

Support for each option varies within CHA membership.

The Rudd government has vowed to end the 'blame game' and a change to governance arrangements rather may assist. Currently there is an implicit conflict of interest with the States and Territories owning the majority of hospital service providers and also significantly funding and purchasing these services. This conflict has been played out in both aged care and acute and community care, where cost shifting is rife.

Health financing

Private vs Public financing in Australia

1946	National pre-paid hospital system introduced by Chifley Labor government National health service failed, opposed by medical profession
1950's	Menzies government abandoned pre-paid hospital scheme and introduced publicly subsidised private health insurance
1975	Medibank introduced under Whitlam government
1976	Fraser government -Medibank dismantled and voluntary health insurance re-instated
1984	Medicare introduced under Hawke government –national health insurance scheme • Proportion of people with private health insurance reaches a low of 30.6% in 1998 • Bulk billing increases • Health costs as a % of GDP stable • Proportion of work undertaken in private hospitals increases (John Deeble)
1996	Howard government changes incentives around private health insurance • Abolished commonwealth dental program • Private health Insurance Incentives Scheme introduced (means tested subsidy for private health insurance) • Medicare Levy surcharge of 1% introduced
1999	• Uncapped non-means tested private health insurance rebate introduced • Medicare Levy Surcharge applied to people over 30 years old who do not hold private health insurance • Life Time Health Cover introduced • $8.7 million publicity campaign "Run for Cover" highly successful in increasing numbers of people with private health insurance
2002	• Declining levels of bulk billing and increases in user charges
2004	• Medicare Plus –leads to increases in bulk billing rates • Rates of private health insurance reach 44%
2008	• Rudd Labor government attempts to increase the threshold at which the Medicare levy surcharge is introduced, for those who do not have private health insurance. • Threshold levels changed downwards due to lobbying from industry and lack of accurate treasury forecasting
2009	• 2009 budget forecasts reduction in private health insurance rebate and an increase in the Medicare levy surcharge.

The differences in ideology across Liberal and Labor governments is played out in the public policy arena, especially in the financing of health care. Liberal governments have always favoured minimum government intervention in health policy, with a greater role for private medicine and private insurance. Labor governments argue that health should be publicly financed in order to achieve access and equity objectives. CHA and its members need to consider what has happened in health policy financing, under different governments to anticipate the directions this government will move in.

The Australian health and aged care system is complex. The Federal Government, through the Department of Health and Ageing, sets national health policies and subsidises the health services provided by State and Territory governments and the private sector. The federal government funds universal access to medical services and pharmaceuticals, financial assistance for public hospitals, residential care facilities, hostels, home and community care, and support for training of health professionals and tertiary students. The Federal Government is also the major source of funding for health research.

The Federal Government's regulatory roles include overseeing the safety and quality of pharmaceutical and therapeutic goods and

appliances, managing international quarantine arrangements, ensuring an adequate and safe supply of blood products, and regulating the private health insurance industry. It also regulates food safety and product labelling.

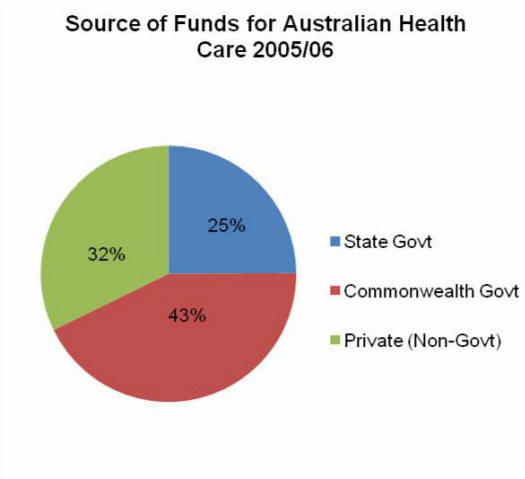
State and Territory governments are responsible for delivering health services, including most acute and psychiatric hospital services. They also provide areas of healthcare including school, dental, child and maternal, occupational, disease control, and various health inspection functions. They are also responsible for regulating health professionals, although this function will change with the introduction of National Registration.

State and territory government regulatory roles include responsibility for licensing or registering private hospitals (including free-standing day hospital facilities). Each state and territory has legislation relevant to the operation of public hospitals. They are also largely responsible for industry regulations, such as the sale and supply of alcohol and tobacco products.[3]

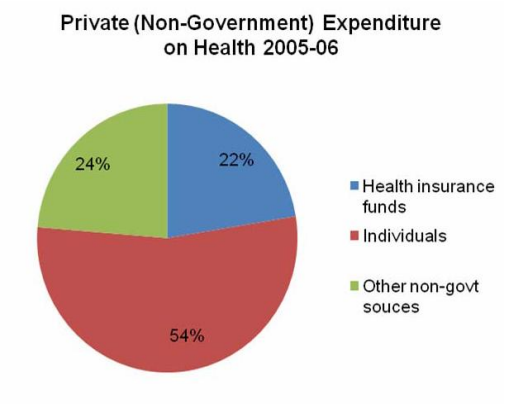
The private sector, including Catholic health and aged care services also play a key role in finance and delivery of health services.

In 2005-2006 two thirds of Australia's health care expenditure was funded from tax revenue through Medicare, and one third was funded through the private sector –through insurance or direct out of pocket payments. But only one-third of the spending occurred in the public sector and two-thirds of the spending occurred in the private sector –across a wide range of governance arrangements[4].

The following graphs detail the source of funds for Australian health care and private expenditure on health.



AIHW 2007a



AIHW 2007a[5] [6]

In 2009-2010 Federal budget, government aims to change existing private health insurance arrangements. Subject to legislative approval, the private health insurance rebate will be reduced for higher income earners. The impact that this policy change will have on the Catholic private hospital

[3] Information accessed from DoctorConnect website, http://www.health.gov.au/internet/otd/publishing.nsf/Content/work-gov-responsibility, accessed 5/5/09

[4] Foley,M: July 2008: A Mixed Public –Private System for 2020 – a paper commissioned by the National Health & Hospitals Reform Commission, p.4

[5] Australian Institute of Health and Welfare (AIHW 2007a), *Health Expenditure Australia 2005-06*, AIHW, Canberra, 2007. Available at http://aihw.gov.au/publications/index.cfm/title/10529

[6] More detail on Australia's health financing can be found in Foley,M: July 2008: A Mixed Public –Private System for 2020 http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/$File/A%20Mixed%20Public-Private%20System%20for%202020%20(M%20Foley).pdf

sector is not known as yet, and it appears difficult to model.

Following this recent announcement Treasury has estimated that the change will only see 25,000 leave private health insurance[7] .

Over the next three years at least, individual hospitals or groups of hospitals will continue to face a difficult negotiating environment with health funds in negotiating the agreements on which their viability and ability to invest in staff and facilities depend. The success of the Catholic health care sector may end up being dependent upon closer integration.

An example of where closer integration has worked well for some services is the Catholic Negotiating Alliance (CNA). CNA has been able to bring together various Catholic healthcare organisations, and achieved collaboration – particularly in relation to purchasing. This is a significant achievement.

Do CHA members need to be more closely integrated in order to remain viable? If yes, in what ways could this happen?

All this information leads to identifying the risks associated with dependency on government policy, as is evident in the private health arena.

There are increasing pressures applied to Catholic public hospitals by state governments in their dealings with the sector. The recent announcement by the ACT government of its intention to purchase the Calvary Public Hospital and the tight funding of Catholic public health services is illustrative of this tension between health funders and Catholic providers,.

Below is a case study about the National Employment Program and what happened to Catholic employment programs when government policy was signalled as changing and the sector did not respond.

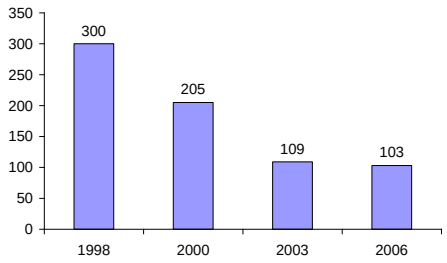
***What are the implications for CHA and its members if publicly funded services are renegotiated unfavourably on a state by state level or indeed at a Commonwealth level?**

***How can CHA achieve unified action within CHA on public policy issues given the mixed health system of both public and private services? Is this desirable?**

Dependency on government policy – a case study National Employment Programs

90% of funding for employment services in Australia is provided by the Commonwealth and administered through DEEWR. Over time there has been an observable trend in the manner in which DEEWR has been providing funding that has reflected the shift to a smaller number of large providers. Graph 1 illustrates this trend.

Graph 1: Job Network Provider Attrition 1998 to 2006



In February 2007, Catholic Social Services Australia (CSSA) provided agencies with an assessment of their relative prospects of survival based on each agency's scale and diversity of DEEWR-funded programs. With regard to future survival, CSSA's strategic advice to agencies was two-fold:

- CSSA's vocational services network needed to merge its national and local DEEWR contracts and become a more cohesive national whole with more efficient infrastructure.

[7] Department of Health & Ageing official, quoted budget night lock up, 12 May, 2009

- Agencies with one or two DEEWR programs needed to diversify their program base.

This was not achieved. Some agencies were unwilling to surrender local control to a national entity, some agencies were dissatisfied with national arrangements, some agencies were increasingly uneasy working with DEEWR.

In May 2007, the CSSA Ltd Board, concerned that existing arrangements did not allow it to fulfil its contractual obligations adequately, advised it would not hold future contracts under current arrangements. Two internal reviews and one external review were conducted during 2007 and 2008 and all drew similar conclusions that arrangements other than national were doomed to eventual failure in the DEEWR program environment.

By October 2008, most agencies had decided to either withdraw from these services or tender outside the national arrangements and the CSSA Ltd Board decided to withdraw from national contracting and instead offered to support individual agencies who wished to tender locally.

The results of the current tender round mean a dramatic reduction in the number of agencies involved in employment services (from 30 to 7 – down 77%), a dramatic reduction in revenues (from $38 million to approximately $20 million – down 48%) and a reduction in national coverage (from 44% to 16%) – a fall of 64%.

The obvious questions that arise from this process include:

What are the implications for the future provision of employment related services by church agencies if current trends continue?
What are the implications for other funded social service programs delivered by Catholic agencies?
How can the barrier to unified action within the Church be overcome?

3. Aggiornamento (Renewal)

Development of the CHA Strategic Plan 2009-2011 needs to focus on and balance both Catholic identity issues and the immediate public policy concerns.

The Catholic health care ministry is an essential ministry of the Church. There are many challenges that confront the ministry of Catholic health care. Pope Benedict XVI has spoken on the need for an 'aggiornamento' of Catholic health care, which literally means 'open the window', and implies renewal and deepening of the pastoral process itself.

There are common challenges that confront the ministry across the world.

- Accountability and transparency are critically important
- Conflicting priorities and limited financial resources lead to inadequate private and public resources to fund the work of the ministry
- Legalisation of abortion and euthanasia and bioethical directions that limit the ability of the ministry to preserve and protect the dignity of human life
- The health care needs of the poor and vulnerable are ever present
- There is growth in the ministry in some parts of the world, consolidation in others
- Leaders in the ministry are evolving with the laity sharing more responsibility[8]

Conclusions of the Third International Congress of the International Federation of Catholic Health Care Institutions in May 2007 agreed to promote the 'aggiornamento' of the ministry under the title "Advancing our stewardship of the ministry". The following recommendations were made, and are particularly pertinent to our CHA Strategic Planning process:

1. Catholic health care entities should articulate the essential characteristics of the ministry and provide measurable outcomes that can be actualised in the organisations' strategic planning process.
2. Provide an integrated approach to the professional and ministerial development of all those who serve in the ministry. The approach should be developed in a manner appropriate to their mode of service and reinforced by ongoing formation and continuous evaluation.
3. Deepen understanding of, and commitment to, collaboration within the ministry and with other ecclesial ministries.
4. Collaboration as appropriate, with secular entities, in a manner that does not compromise Catholic identity.
5. The ministry should become known for its special commitment to providing health care to the poor, marginalised and vulnerable in a manner that truly advances their human dignity and does not encourage dependency. This commitment should be expressed in a strategic and transparent manner that is facilitated by efficient and effective models of care.
6. Catholic health care should be known for its advocacy for access to health care being a fundamental human right. Such advocacy should be based on accurate social analysis, made effective by the appropriate training and education of those who would carry it forward.[9]

[8] Place, Michael, Rev, Chairman AISAC, (International Federation of Catholic Health Care Institutions): Dolentium Hominum N. 66-2007, p.9

[9] Place, Michael, Rev, Chairman AISAC, (International Federation of Catholic Health Care Institutions): "Conclusions of

To help frame our focus on Australia it may be beneficial to look to our peers.

What are international Catholic Health organisations focusing on? A focus on the US and Canada

Catholic Health Association of Canada (CHAC)

CHAC has recently developed a Strategic Framework. The CHAC aims to pursue a mission of strengthening and supporting the ministry of its member organisations and individuals. The CHAC has two mandates:

1. To foster the distinctive mission and organisational culture of Catholic health care organisations – the Catholic Governance Mandate, and
2. To be the national voice of Catholic health care organisations on matters pertaining to public policy and the health care system – the Advocacy Mandate.

The CHAC pursues 5 strategic objectives:

Catholic Governance

1. Strengthen the governance of Catholic health care organisations
2. Promote excellence in Catholic health care

Catholic Governance and Advocacy

3. Promote the mission and objectives of Catholic health care

Advocacy

4. Promote justice and equity in the health care system
5. Foster the dignity of the person in public policy

Mindful of the scope of its mandates, and with its eyes set on its objectives, the CHAC focuses its effort and resources along three paths or strategic directions:

1. Developing and disseminating governance resources,
2. Nurturing the network of members across Canada, and
3. Advocating on behalf of members from a pan-Canadian perspective.

The directions CHAC have taken resonate strongly with CHA. In the past 6 -12 months there has been a consultation process; a concerted effort has been made to nurture the network of members across Australia and New Zealand; and CHA's advocacy role has featured prominently within the media.

Other CHAC activities:

Values integration

Under the auspices of the Joint Associations and PJP Sponsors group, phase 1 of CHAC's evaluation of the Values Integration Appraisal process was completed in May 2005. Recommendations to automate the survey and benchmarking elements of the process are the subject of phase 2 aimed at preparing and implementing the plan. Phase 3 will see the implementation of the process using new tools and guidelines.

Health, Ethics and Spirituality Resources.

CHAC have produced the following publications:

- A Compendium of the Catholic Health Association of Canada
- Living with Hope in Times of Illness
- Healing the Whole Person
- Health Ethics Guide
- Standards of Spiritual and Religious Care for Health Services in Canada
- Facing Death, Discovering Life
- Lift Up Your Hearts to the Lord
- Spirituality and Health
- Justice in the Workplace
- Prescriptions for a Healthier Canada
- Integrating Health & Values: Toward a Shared Vision
- Called to Health and Healing: A Discussion Guide
- Resource Allocation in The Health Care Sector: An aid for ethical decision-making

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the third International Congress of the International Federation of Catholic Health Care Institutions"; Dolentium Hominum N. 66-2007, p.74

- Faithful to a Mission
- The Mission to Care for the Sick
- Governance/Sponsorship Models of Canadian Catholic Health Care Organizations

CHAC have produced the following pamphlets

- Palliative Care
- Euthanasia
- Advance Directives: Planning Ahead for End-of-Life Healthcare Decisions
- Making Decisions About CPR

Leadership Development

The development of leaders in Catholic health care is seen as a critical need by the Joint Associations and PJP Sponsors group, of which the CHAC is an active member. Prior to its restructuring, the CHAC had designed and offered a three-year program of instruction in Catholic health care. Currently, a review of Catholic leadership programs is being conducted under the auspices of the Joint Associations and PJP Sponsors group, of which the CHAC is a member.

Communities of Practice

A Community of Practice (CoP) is a self-directed group of people who join together out of a need to explore topics from their shared experience. Each year, the CHAC makes time and space available during its convention for delegates drawn from different disciplines of Catholic health care to meet each other, sometimes for the first time, and engage in a dialogue related to their discipline. Delegates find these informal "meet and greet" sessions to be a valuable way to begin the convention.

Advocacy outcomes & goals

- Assisting Catholic health care organizations to position their unique organizational culture, qualities and achievements within the health care system
- Promoting justice and equity in the delivery of health care in Canada.
- Fostering the dignity of the person in public policy.
- Developing new advocacy tools/resources to promote grassroots advocacy.

Advocacy issues covered

- Faith-based and ethical concerns
- Wait lists
- Health human resources
- Euthanasia and assisted suicide
- Palliative and end-of-life care
- Health care system
- Legislation
- Health sector GST

Coalitions formed

- Quality End-of-Life Care Coalition of Canada (QELCCC)
- Ecumenical Health Care Network (EHCN)
- Health Action Lobby (HEAL)
- Canadian Health Coalition (CHC)

The Catholic Health Association of the United States (CHA-USA)

CHA USA have a staff of 71 people.

CHA USA is committed:

- Especially to those who are impoverished and most in need and to changing the conditions that perpetuate poverty
- To the belief that health and well-being are basic human necessities and acting in ways to create health care — both coverage and access — that works for all
- To meeting the needs of the communities we serve by reaching out beyond our walls through services that foster health and well-being
- Fulfilling our moral obligation to provide quality health care in respect for the human dignity of each person we serve
- Protecting the fundamental rights of all individuals by acting to end injustice, and discrimination, especially in health care
- Honoring the gift of creation by protecting the environment and using resources responsibly.

CHA-USA has developed a “Shared Statement of Identity for the Catholic Health Ministry” which included agreement across all catholic health and aged care leaders and owners.

Mission Services

CHA USA's Mission Services Department provides numerous programs, services and resources to help Catholic health care providers live out their mission statements, make ethical decisions and foster vital sponsorship

By Their Fruits You Will Know Them: Mission Assessment and Measurement, - is a "clearinghouse" that makes available important examples of mission assessment and measurement. The resource includes four parts. Part I focuses on mission assessment; Part II, on measurement. Part III provides sample mission structures, which consist of organizational charts and mission leader job descriptions and Part IV includes additional examples and resources provided by members of the ministry, as well as CHA.

Ethics

The theology and ethics function at CHA-USA seeks to provide assistance to its members in navigating the many complex ethical realities in health care today. This is done through consultations, presentations, hosting dialogues and working groups, collaborating with colleagues, developing and sharing resources, offering educational programs, and research and writing. CHA-USA provides numerous ethics resources for its organisations. Some of these have been produced by CHA-USA, others are the result of ministry colleagues sharing their successful practices.

Community Benefit

Community benefits are programs and services designed to improve health in communities and increase access to health care. They are integral to the mission of Catholic and other not-for-profit health care organizations, and are the basis of tax exemption.

Catholic and other not-for-profit health care organizations demonstrate their commitment to community service through organized and sustainable community benefit programs providing:

- Free and discounted care to those unable to afford health care
- Care to low-income beneficiaries of Medicaid and other indigent care programs
- Services designed to improve community health and increase access to health care

In the last fiscal year, Catholic-sponsored, not-for-profit member hospitals contributed more than $5.7 billion in services identified as community benefit using CHA- USA's guidelines.

Community benefit is also the basis of the tax-exemption of not-for-profit hospitals. The Internal Revenue Service, in its Revenue Ruling 69–545, describes the community benefit standard for charitable tax-exempt hospitals.

A community benefit must respond to an identified community need and meet at least one of the following criteria:

- Improve access to health care services.
- Enhance health of the community.
- Advance medical or health knowledge.
- Relieve or reduce the burden of government or other community efforts.

Advocacy

CHA-USA's advocacy efforts strive to shape the impact of federal legislation and policies – similar to CHA Australia’s advocacy efforts. Based on priorities determined collaboratively by the membership, staff, Advocacy and Public Policy Committee, and the CHA board, the advocacy team — located in Washington, D.C., focuses on initiatives that not only strengthen the viability of the Catholic health ministry as not-for-profit providers but also support the ministry's emphasis on enhancing the current health care system to create a just and compassionate health care system.

Elder and Continuing Care

Serving the elderly and those who are chronically ill is an essential part of CHA-USA ministry. Catholic-sponsored health organisations provide a broad spectrum of professional services, including

acute and primary care, nursing home, medical and social day care, home health, senior housing and assisted living, counseling, case management, etc.
CHA- USA helps its members to:

- Provide holistic, person-centered, high-quality care
- Respond compassionately to the needs of aged and chronically ill persons
- Work collaboratively with others holding similar values to offer a continuum of services
- Integrate and coordinate care across settings for continuity of care
- Provide a workplace where the value of each staff member is respected
- Advocate for just public policies

Climate Change
CHA-USA have developed a theology of caring for the environment and why those in Catholic ministry should be especially mindful of this global challenge and attentive to corrective measures.
CHA-USA has launched a ministry–wide effort to raise awareness about global climate change with the aim of developing educational programs and to build collaborative activities. The goals are to respond to energy efficiencies within health care facilities as well as explore the health care impact on persons who are poor and how Catholic health care might better respond.
CHA-USA will provide leadership for others in the ministry by:

- Developing resources that include an educational booklet and other instructional and motivational materials on climate change
- Presenting information about climate change and what Catholic health care can do to mitigate the problem
- Assembling a faculty of experts available to mentor facilities motivated to decrease energy use and emissions.
- Creating an action plan for decreasing energy consumption and emissions in the health care organizations as well as in the work and personal lives of associates.
- Collaborating with other organizations to build consensus and replicate successful practices that decrease energy consumption.

Health Reform
CHA-USA have developed a vision from values in relation to health reform. The Catholic health ministry envisions a US health care system designed to create and sustain a strong, healthy national community.
To move the reform forward CHA-USA intend to continue to lead and work in coalitions focused on creating a health care system that works for everyone and promotes the health of the national community. It continues to facilitate the Catholic health ministry's evaluation of health reform proposals. And finally it will invite lawmakers and local leaders to participate in community dialogue on how best to approach systemic reform; engage the U.S. public in clarifying its vision for health care and facing the implications of values and priorities. This document was written in anticipation of a new government replacing the Bush Administration.

Other areas CHA-USA have focused on include:
Care for the poor - Key among those commitments is what the church calls, "the preferential option for the poor."
Diversity - both in the workforce and in meeting the needs of diverse patients
Human trafficking - Catholic and other health care organizations and their health care professionals can help victims of human trafficking by being alert to the problem and realizing patients they are treating may be victims.
Immigrants – CHA-USA has a specific commitment to helping those who have come to the United States from other countries. Through outreach, education, and advocacy, CHA speaks out on behalf of health care access for immigrants and collaborates with other organizations in "welcoming the stranger among us."
Quality & Patient Safety - Catholic health care is not only committed to providing quality care and ensuring patient safety as health care providers but also through its ministry's commitments to the

social teachings of the Catholic Church and our obligation to carry on the healing ministry of Jesus Christ on earth.

Environmental responsibility – CHA USA has the power and responsibility to make health care more environmentally responsible and safe. The environmental footprint produced by CHA-USA health facilities has health consequences not just for patients, but also for staff and the communities served

Strengthening Catholic health care – in the USA Catholic health care organisations work together to advocate necessary public policy changes, train leaders for the future, and preserve their ability to serve in keeping with Catholic values.

Committees operating within CHA-USA

Advocacy & Public Policy
Audit & Compliance
Diversity
Executive
Finance
Governance

CHA -Australia

Catholic Health Australia:

- Takes a leadership role in supporting and strengthening its membership to develop individually and collaboratively to ensure the healing ministry flourishes as an integral part of the mission of the Catholic Church.
- Promotes a just system of health and aged care delivery that has at its heart an imperative for those who are poor and marginalised.
- Is the unified public voice for the members on matters of common interest.

Supports the following Committees

- Health Committee
- Aged Care Committee
- Education and Formation Committee
- Directors of Nursing & Midwifery Committee

CHA have produced the following publications:

- Aged Care Policy Blueprint 2020
- Ministering to People with Dementia: A Pastoral Guide
- A 'Preferential Option for the Poor'
- Being a Catholic Hospital
- Code of Ethical Standards
- Catholic Care of the Ageing
- The Care of Persons with Dementia in Catholic Aged Care
- On Being Pastoral
- Crafting Catholic Identity in Postmodern Australia

And the following pamphlets:

- End-Of-Life Issues
- Advance Care Planning Documents
- Nutrition and Hydration Guidelines

Other information about the CHA Australia sector has been detailed elsewhere in this paper.

4. Strategic Challenges for Catholic Health Australia

Australia is in the midst of one of the most difficult times it has faced in most peoples living memories. The Global Financial Crisis, climate change, including increasing water scarcity, a rapidly ageing population and increasing social disadvantage.

The health and aged care sectors must take account of their specific challenges into the future, including how to:

- Meet the needs of ageing population,
- Address the increasing burden of chronic disease,
- Ageing workforce,
- Ensure coordination of care that, especially in the aged care environment, is client centred and where possible and practical, user controlled
- Support early intervention and prevention,
- Ensure access to their services, and
- Ensure transparent outcomes.

CHA members will be required to concentrate efforts and resources if they are to remain competitive. CHA itself will need to work hard to remain relevant through its ideas and services offered to members.

Workforce

The health and aged care sector is a key economic sector employing significant human capital. Investment in this pool of human capital is essential to recruitment and retention in a globally competitive market.

Health workforce issues have been identified by virtually all health policy groups as a key priority for health planning. This issue was not really on the radar ten years ago - the environment has changed significantly. There is a need to develop reliable forecasting approaches and strategies for recruitment and retention. The magnet hospital concept has been raised in relation to retention and quality of the workplace within CHA, by nursing groups approaching recruitment and retention issues in terms of quality of the workplace and nursing roles in the delivery of health care. Health services research will play a key role in the development of evidence-based nursing practice. While recruitment and retention are important, of equal importance are the compensating strategies for workforce shortages, including the use of telemedicine and related technologies, task substitution, role delineation and competency frameworks. CHA has the opportunity to work closely with the newly designated Health Workforce Agency in developing innovative solutions to workforce issues.

Volunteers also play a significant role in the health sector now and into the future. The role and contribution of this sector in the community care arena has not been well researched and may have significant implications concerning integrated service delivery and community care capacity.

Health Reform

For CHA members to be successful in the health reform environment any reform will need to preserve or create a seamless service delivery system. For example, developing clinical pathways within a disease management framework that can move from management of acute care into chronic care, and be applied in the aged and community care environments.

Health technology assessment will play a key role in the future. Increasing use of cost-effectiveness studies and evaluation of various other existing and emerging technologies are areas for the future. CHA members will need to maintain pace with advancing technologies and to make this research evidence more accessible both in terms

of broad distribution and packaging of the research product.

Measuring Performance

The government is working towards ensuring health and aged care services are optimally accountable and transparent. CHA will see a greater emphasis on reporting requirements to government. System performance indicators will measure performance against key policy objectives of efficiency, effectiveness, equity and quality. Performance indicators will vary across sectors with quality, safety and cost central to all.

To assist in this process CHA could develop a national framework for use within CHA to transparently report system wide indicators back to the sector.

The framework may be broadened to include mission measures, as well as reporting on financial health, particularly of aged care.

In aged care, government policy has resulted in most smaller facilities going out of business. A mechanism to assist Catholic aged care providers ensuring that Catholic services are kept in Catholic hands may be welcomed.

Not for Profit organisations

Sustainability issues raise the question of viability of the not for profit system overall. It has overtones of impending problems that threaten the fundamental principles upon which the not for profit system is founded. The current Henry Review into taxation may throw some changes CHA members' way in terms of its not for profit status.

The Productivity Commission is also reviewing the contribution of the not for profit sector and are assessing measures of the sectors contributions. They are also examining the impact of the taxation system on the ability of not for profit organisations to raise funds and the extent to which the tax treatment of the sector affects competitive neutrality.

The government has identified the not for profit sector as playing a critical role in delivering services, advising and developing social policy and advocating on behalf of marginalised groups. The not for profit sector also plays a critical role in assisting government in achieving its social inclusion agenda. Notwithstanding this, government has indicated a need for changes in governance arrangements underlying its relationship with sector. CHA will need to continue to be well across these issues into the future.

Global Financial Crisis

The current global financial crisis and its likely impact on the Australian economy will also have an impact on the country's health services. It is anticipated that increased numbers of low and middle income earners will seek the services of welfare agencies[10]. It could also be anticipated that a proportion of this cohort of people, should they hold private health insurance, may cancel their policies. Access Economics[11] reports that even during the relatively good economic times experienced recently that social service agencies were reporting a growing demand and the emergence of a "new clientele of 'mid-stream' wage earners facing severe financial stress".

The extent to which economic growth will slow down is unknown. In this year's budget the government has promised $1.5 billion in savings over the next financial year, with more to follow over the next four years. The deficit sits at $53.1 billion which is nearly 5% of GDP, and it is predicted that Australia will average -0.5% growth and unemployment of 8.25%. The government, within this latest budget, has become the highest spending government in Australian history, with expenditure equalling 28.6% of GDP.

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[10] Access Economics: November 2008: *The impact of the global financial crisis on social services in Australia: An issues paper prepared for Anglicare Australia, Catholic Social Services Australia, The Salvation Army and UnitingCare Australia*

[11] Op cit, Page 1

The demand for social services is rising, and it is likely that the nature of the demands on social services is likely to change. In residential aged care, for example, demand has outstripped the capacity of agencies to offer assistance.[12] According to the Australian Community Sector Survey 2008, services in relation to residential aged care had to refuse assistance to 13.4% of eligible people who sought assistance (although response rate to the survey was not as high as anticipated, so results may not be a true reflection).[13]

CHA has argued in the past that social factors such as a person's level of education, their home life, and their financial resources are in some cases stronger influences on a person's health and well being than biomedical factors. As many Australians – individuals and families – face the impact of this recession and its economic downturn, it is likely that demand for social services will increase and that people's long term health and well being may be compromised. Addressing these social determinants of health through a social inclusion agenda that includes targeted policies taking account of the economic downturn may ameliorate some of this negative impact on health and well being, and hence CHA's health and aged care facilities.

Within CHA there is variety in the financial structures of different service providers', some have been heavily exposed to losses on the financial markets. Providers who have relied on investment earnings for operating revenue may have been significantly affected. This in turn may affect members' ability to undertake mission-based projects or capital intensive projects, or indeed remain members of CHA.

The government's stimulus in this budget focuses on massive road and rail investment, multi-billion dollar clean coal and solar technology fund, more educational investment and a substantial lift in the pension rate. Whilst these expenditures are mostly targeted policy measures there does not seem to be any particularly targeted to the health and aged care sectors.

In the health portfolio an additional $3.2 billion will be spent on hospitals - $1.5 billion for infrastructure, $1.3 billion for a national approach to cancer care and $430 million across research. A review of pathology and imaging services is planned. From 1 July 2010, all pathology providers will be able to have as many collection centres as they choose. Legislation will be changed to ensure that patients can choose their pathology provider for testing requested by their doctor and still be eligible for a Medicare benefit. These changes to pathology will pose a significant challenge for CHA providers of pathology services.

There are significant changes proposed to the Private Health Insurance rebate, and these are discussed elsewhere in this paper.

The global financial crisis is likely to affect how Catholic health and aged care services are delivered and is already affecting how some Catholic welfare providers orient their services. See below.

[12] Op cit, Page 1

[13] ACOSS, *Australian Community Sector Survey, June 2008*

An opinion piece written by John Picot, CEO of the NSW St Vincent de Paul Society[14].

" A new homeless shelter will be opened by the St Vincent de Paul Society in inner Sydney this year. But unlike other hostels, those which cater for single men - such as the Matthew Talbot in Woolloomooloo - this one will mainly accommodate families.
It is testament to the times that we know it will always be full... The reality is that sheltering and assisting whole families has become the pressing priority for charities. The new Vincentian House will replace a smaller hostel, which over the past few months has been turning away 10 times as many families as it can take. It will provide a home to 24 families on any one night. That's the equivalent of almost an entire school classroom of families in one pocket of Sydney alone. It will accommodate children who would otherwise have had no home to go to, no bath to have, no bed to sleep in.
Alarmingly, we are also seeing families becoming homeless who were previously in the private housing market. Home owners. This is unfamiliar territory for us ... The world is not simple any more, and to navigate it requires skills that more and more people either don't have, or can't sustain.
That inability to cope can lead to mental illness, drug, alcohol or gambling addictions. Those factors affect relationships at home, at work and socially. The slide is easy.
Those same complexities mean as a charity we face our own challenges which require more effectively managing responsive and flexible support. Pressure placed on our volunteers and professional staff means we, too, are pedalling faster than ever just to deliver on our core mission.
Can we simplify the world and its systems? No, but we can, and must, develop support services that guide people through it and develop their coping skills to navigate the hurdles".

[14] 4th May, 2009, Sydney Morning Herald: http://www.smh.com.au/opinion/life-on-the-streets-families-are-the-new-face-of-homelessness-20090504-asn3.html?page=-1, accessed 4/5/09

Does CHA and its members have a role to play in advocating to ensure that health and social services are considered in building the "path back to surplus"?

Ethical Issues

In the future CHA will be required to provide even greater assistance to its members in navigating the many complex ethical issues in health care.

Over the past 12 months alone CHA has responded to a Senate inquiry relating to euthanasia, the Victorian legislation to legalise abortion and the Victorian Bill supporting patient assisted suicide. We know there are more bills in other states and territories waiting to be heard – South Australia and New South Wales is proposing to legalise abortion, and Western Australia is working on a euthanasia bill.

In order to respond to these inquiries and legislation CHA will be required to continue to consult with members and the Church, as well as host dialogues.

There are a number of Catholic sponsored ethical and bioethical bodies in various Australian states. It would greatly assist in addressing this particular strategic challenge if these groups and CHA could respond in a more consistent way, as these ethical debates will not abate.

5. Conclusion: Critical issues facing CHA and its members in 2009 -2011

1. Increasing number of ethical debates in the public arena
2. Uncertainty of public policy directions for health reform, including health financing
3. Inadequacy in health and aged care funding
4. Reform of health workforce in a way that meets increasing service demand
5. System performance indicators –government will be looking for increasing transparency in reporting
6. Continuance of charisms to ensure enduring ministries
7. Sustainability of the not for profit sector and its capacity to continue to be an instrument for social justice and service delivery

Appendix 1

National Health & Hospitals Reform Commission key proposals:

- Universal entitlement to medical, pharmaceutical and public hospital services under Medicare, together with choice and access through private health insurance.

- Maintain the current balance of spending through taxation, private health insurance and out of pocket contribution.

- Strengthen incentives to improve outcomes and efficiency through use of activity based funding for hospitals, case payments for primary care and payments that reward good performance in outcomes and timeliness, supported by public reporting of performance against national indicators.

- Three options for Governance were proposed and it is widely understood that the Commission will recommend adoption of Option C: *Commonwealth to be solely responsible for all aspects of health care, funded through compulsory social insurance and delivered through multiple competing health plans for people to choose from.*

- At a minimum, however, it likely that the Commonwealth will take full responsibility for primary care and aged care (including HACC).

- In terms of Aged Care the report strongly supports increasing consumer choice and competition in service provision –as supported by CHAs Aged Care Policy Blueprint. It does advocate to continue to ration the number of care recipients that it subsidises through the provision level being based on care recipients per 1,000 people 85+, administered by ACATs. Although this measure would increase the availability of aged care services over the next thirty years, it still involves the rationing of services and is not a good measure of need. CHA supports an entitlement system based on assessed need by a national independent care assessment and information network (a reinvigoration of ACATs under Commonwealth legislation and control to become Access and Information Centres).

- The Commission recommends that the number of aged care places should no longer be restricted. CHA agree with this direction, subject to transition issues being addressed to reduce financial risk to providers and hence risk to continuity of care for existing residents, especially if implemented in conjunction with greater consumer choice over community or residential aged care. The lifting of supply controls will need to be phased in accordance with an announced timetable to allow providers time to adjust their business plans and models, and absorb the balance sheet and P&L implications of the write down in the former scarcity value of bed licences.

- The Commission recommends the introduction of bonds in high care or alternative approaches as options subject to increased competition in supply and price. CHA agree but this arrangement should apply to all residential aged care; the current distinction between low and high care should be discontinued as it would serve no useful purpose

- Funding linked to care recipient and changing basis for provision to care recipients per 1,000 people 85+

- Facilitate locally designed and flexible models of care in rural and remote communities through the expansion of Multi Purpose Services

- Permit accommodation bonds in high care subject to lifting of supply limits resulting in sufficient increased competition in supply and price.

- Require aged care providers to make standardised information on service quality and quality of life publicly available

- Consolidate aged care under the Commonwealth by making aged care under the HACC program a direct Commonwealth program
- Developing and introducing streamlined, consistent assessment for eligibility for care across all aged care programs
- A more flexible range of care subsidies for people receiving community care packages, determined in a way that is compatible with care subsidies in residential care.
- People who can contribute to the costs of their own care should contribute the same for care in the community as they would in residential care (not including accommodation costs).
- People supported to receive aged care in the community should be given the option to determine how the resources are used to support their care.
- Once assessments care subsidies and user payments are aligned across community care packages, older people have greater scope to choose for themselves between using their care subsidy for community or for residential care.
- All aged care providers have staff trained in supporting care recipients to complete to complete advance care plans for those care recipients who wish to do so.
- Funding be provided for the national implementation of the Respecting Patient Choices Program (advance care planning).
- Funding to allow residential aged care providers to strike arrangements with primary care providers and geriatricians to provide visiting and on-call medical care.
- Strengthening capacity and competence of primary care services, including the Comprehensive Primary Care Centres, to provide generalist palliative care support.
- Strengthen access to specialist palliative care services for all relevant patients across a range of settings, especially for people living in residential aged care.
- Increased use of electronic clinical records in aged care homes
- The hospital discharge referral incentive scheme to encompass provision of clinical information to aged care providers
- Increase the visability of, and access to, sub-acute services through more direct linking funding to the delivery and growth of sub-acute services (using both activity based costing and incentive payments)
- Commonwealth should assume responsibility for all primary health care policy and funding.
- Commonwealth to support the expansion of Comprehensive Health Care Centres
- Governments must collaborate to develop a strategy for ensuring that older Australians, including those in residential aged care, have adequate access to specialty mental health and dementia care services.
- The reports primary recommendations in relation to hospitals include the development of National Access Guarantees for planned procedures and National Access Targets for emergency care; reward for good performance and timeliness; introduction of activity based funding for both public and private hospital inpatient and outpatient activity; and a requirement that public and private hospitals report publicly on performance.
- In relation to Aboriginal and Torres Strait Islander health is the recommendation that an Aboriginal and Torres Strait Islander health Purchasing Authority be established to purchase services from accredited providers specifically for Aboriginal and Torres Strait Islander Australians.