Document 1

Australian Government
Department of the Prime Minister and Cabinet

MB09/13

Prime Minister (for meeting)

Secretary
Mr Tune
Ms Wilson
Mr English
Ms Cass
s 22(1)(a)(ii)

Dr Philip
Mr Jordan
Mr Kumar
Mr Fredericks

[File LA]

Briefing by Minister Roxon and the National Health and Hospitals Reform Commission (NHHRC) on the NHHRC Interim Report

Purpose: To discuss the NHHRC's Interim Report - *A Healthier Future for all Australians*	**Timing:** 3.30pm – 5:00pm Thursday 22 January 2009 **Venue: Melbourne CPO**

Our Objectives (Agenda and Talking points are at Attachment A.)

- To seek further information from the Commission on the major reform areas in the interim report.
- s 47C

Their Objectives (Attendees/Commission Terms of Reference are at Attachment B.)

- To provide a briefing on the NHHRC's Interim Report.

Key Matters

The report is structured around four themes and contains a number of reform directions. An overview of the report and the areas of major reform is provided at Attachment C. Attachment D discusses the areas where the report aligns with current government policy and reform processes.

Primarily, the discussion will be focussed on two major reform areas:

1. Reform options for governance:
   - Option A: Commonwealth takes responsibility for primary health policy and funding. States and territories funded for public hospitals according to activity based funding.
   - Option B: Commonwealth to be solely responsible for all aspects of health care, delivering through regional health authorities.
   - Option C: Commonwealth to be solely responsible for all aspects of health and health care, establishing compulsory social insurance to fund local delivery.
2. Primary Health Care Service reform, including:
   - Commonwealth takeover of all primary health care policy and funding;
   - Voluntary enrolment with primary health providers for chronic, complex and special needs patients; and
   - Workforce roles and funding redesign.

It is expected that the report will be released in the week beginning 16 February 2009.

Attachments

A. Talking Points/Agenda
B. Attendance/Biographies
C. Overview of Report
D. Alignment with current policy and reform

David Tune
Associate Secretary
19 January 2009

NOTED

Kevin Rudd

Date:

QA: s 22(1)(a)(ii)

Contact Officer: Yael Cass s 22(1)(a)(ii)

Consultation: Health

Attachment A
[agenda to come on Monday 19 January]
Talking Points

- Thank you Nicola and Dr Bennett for the overview of the report and power point presentation.
- I'd like to focus the discussion today on two main areas that you talked about, the reform options for governance, and primary health care reform.

Governance options

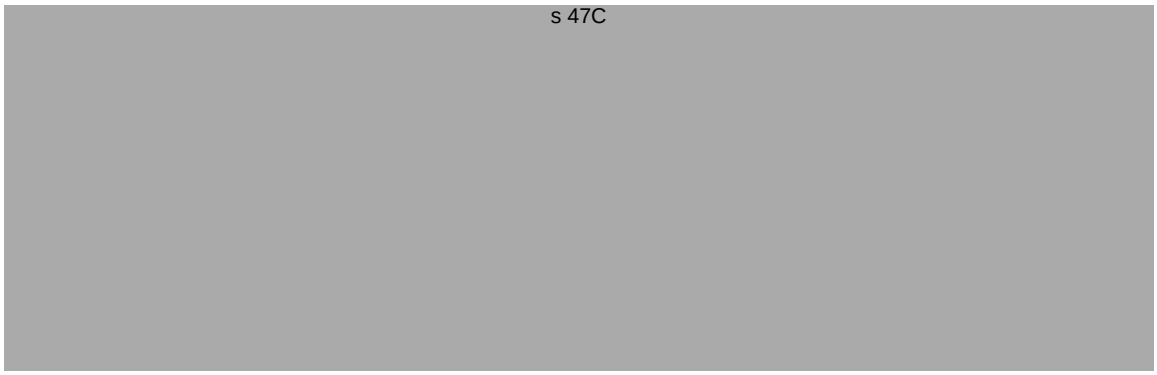
s 47C

Primary care

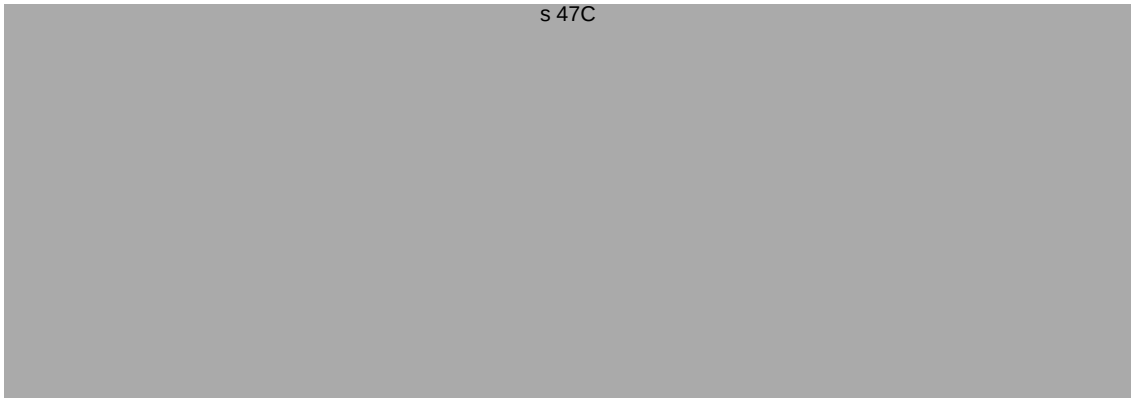
s 47C

If other aspects of the report are to be discussed:

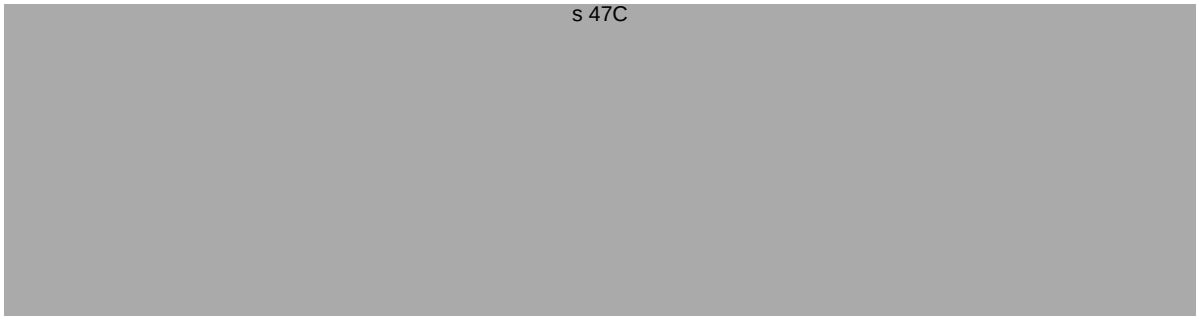
Universal access to dental services funded through a Medicare Levy



Aged Care funding model: person (or voucher) based rather than place based



A national Aboriginal and Torres Strait Islander Health Authority to purchase services under an Indigenous-specific schedule



Attachment B

Meeting Attendees

Minister Roxon
Dr Christine Bennett
The Hon Dr Geoff Gallop AC
Dr Mukesh Haikerwal
Other Commissioners to be advised

Dr Christine Bennett, Chair of the National Health and Hospitals Reform Commission is the Chief Medical Officer of BUPA Australia Ltd, operating as MBF, HBA and Mutual Community. At the time of her appointment as Chair of the Commission, Dr Bennett was Group Executive, Health and Financial Solutions, and Chief Medical Officer of MBF Ltd. Dr Bennett is a trained paediatrician and a Fellow of the Royal Australasian College of Physicians. She was Head of Health Services Planning in NSW Health and worked with Professor Shearman to lead a major reform of maternity services in that state, negotiated the relocation of the Children's Hospital to Westmead, and implemented the NSW State Trauma Plan. She was subsequently the General Manager of the Royal Hospital for Women, and then Chief Executive of Westmead Hospital and Community Health Services. s 47F [redacted]

The Hon Dr Geoff Gallop AC is Professor, Director, Graduate School of Government, University of Sydney. Professor Gallop was the Premier of Western Australia from 2001 to 2006. He was a Minister in the Lawrence Labor Government from 1990 to 1993 (holding a range of portfolios most notably Education, Fuel and Energy and Minister Assisting the Treasurer) and when that Government was defeated in 1993 he took up a range of Shadow Ministerial appointments. In 1994 he was elected Deputy Leader of the State Parliamentary Labor Party and in 1996 he was elected Leader.

As Premier, he oversaw a range of political and social reforms (electoral reform, gay and lesbian equality and a State Administrative Tribunal), upgraded the State's industrial and labour laws, brought a spirit of reconciliation to the resolution of Native Title and developed partnership models for the State's indigenous communities, changed the law to require all 16 and 17 year olds to be in education or training, was the first Premier to commit his government to a major desalination plant, stopped the logging of all of the State's Old Growth Forests creating record numbers of new national parks, restructured the State's electricity and racing industries, and started construction of the Perth to Mandurah Railway and City Tunnel.

Dr Mukesh Haikerwal is a General Medical Practitioner in Melbourne's Western Suburbs where he has practised for over 17 years. He was the 19th National President of the Australian Medical Association in 2007 following 2 years as National vice president and 2 years as Victorian State President.
He is currently working with the National e-Health Transition Authority appraising the clinical health professional community of the benefits of vital role of IT in healthcare. Internationally, he is the Chair of the World Medical Association Finance and Planning Committee.

Other Commissioner Profiles

Professor Justin Beilby is the Executive Dean, Faculty of Health Sciences, which oversees training for medical, dental, nursing, psychology and health sciences graduates at University of Adelaide. Professor Beilby is also a Professor of General Practice at the University of Adelaide.

Professor Beilby has been in general practice in both rural and urban settings for over twenty years. He has been President of the Australian Association for Academic General Practice, and a member of the Strategic Research Initiative Working Group of the NHMRC. Professor Beilby has had a long career in general practice and primary care research, particularly in the areas of financing, chronic disease management, health services reform and quality initiatives.

Dr Stephen Duckett is Chief Executive of the Centre for Healthcare Improvement in Queensland Health, responsible for clinical governance, leadership transformation, health statistics and public reporting and improving hospital access (elective surgery, emergency department care, outpatients) across Queensland. Dr Duckett was formerly (1996 to 2005) Professor of Health Policy and Dean of the Faculty of Health Sciences at La Trobe University. Dr Duckett's research and publications focus on aspects of the Australian health care system (including health insurance, workforce), the economics of hospital care (particularly the use of casemix measures), and safety and quality of hospital care.

From 1994 to 1996, he was Secretary of the Commonwealth Department of Human Services and Health. From 1983 to 1993, he held various operational and policy positions in the Victorian Department of Health and Community Services and its predecessors, including Director of Acute Health Services, in which position he was responsible for designing and implementing Victoria's casemix funding policy. From 2000 to 2005, Dr Duckett chaired the boards of directors of Bayside Health and the Brotherhood of St Laurence. He is an Adjunct Professor at the University of Queensland and Griffith University.

Sabina Knight is a remote area nurse and Associate Professor in Remote Health Practice and Remote Health Management at the Centre for Remote Health in Alice Springs. Associate Professor Knight’s professional activities have been focused on remote, isolated and rural health, in particular Aboriginal primary health care and health inequalities, and she is a recognised leader in remote health nationally and internationally. Associate Professor Knight was a foundation member, and past president, of the Council of Remote Area Nurses of Australia (CRANA), foundation deputy Chair and Chair of the National Rural Health Alliance (NRHA), and Chair of Central Australian Rural Practitioners Association (CARPA) editorial committee producing the internationally recognised CARPA best practice guidelines for remote practitioners.

The Hon Rob Knowles AO is currently Chair of the Mental Health Council of Australia. Mr Knowles is a consultant /adviser in the health sector and has a very high level of expertise in the field of public administration, having been a senior Minister in the Victorian Government for seven years including Minister for Health.

Ms Mary Ann O’Loughlin is Executive Councillor and Head of the Secretariat of the COAG Reform Council. Before she joined the Council in 2008, Ms O’Loughlin had 20 years senior executive experience in both the public and corporate sectors. Formerly a Director of the Allen Consulting Group, a leading economics and public policy consulting firm, Ms O’Loughlin specialises in health and social policy analysis and development. Ms O’Loughlin was Senior Adviser (Social Policy) to the then Prime Minister, the Hon Paul Keating, and held a number of senior positions in the Commonwealth Public Service, including Deputy Secretary of the Department of Employment, Education, Training and Youth Affairs, and First Assistant Secretary, Social Policy, Department of Prime Minister and Cabinet. Ms O’Loughlin has also worked as a senior executive for a major publicly listed health care company.

Professor Ronald Penny AO is one of Australia's leading immunologists and is currently Emeritus Professor of Medicine, University of NSW; and Senior Clinical Advisor, NSW Health. He was Director, Centre for Immunology at St Vincent's Hospital and University of NSW until 2002. He is currently the Co-Chair of the NSW Chronic Aged Community Health Priority Taskforce. Professor Penny was in 1979 awarded the first Doctor of Science for clinical research from the University of NSW, followed by a Personal Chair in clinical immunology in 1998.

Professor Penny has published over 350 medical and scientific papers in prestigious national and international journals. Professor Penny was previously the Co-Chair the NSW State Government's Chronic and Complex Care Implementation Advisory Group; Chairman of the NSW Blood Products Advisory Committee; Chairman of the NSW SARS Task Force, and the Ministerial Advisory Council on Medical and Health Research. Professor Penny has served as Honorary Consultant at many Sydney hospitals and was a member of the Editorial Boards of a number of leading international journals.

Dr Sharon Willcox is the Director of Health Policy Solutions, an independent health consulting company. She has over 25 years experience working in health policy in government and the community sector.

Her government experience in the Victorian, New South Wales and Commonwealth health departments has included a leading role in the negotiations of the 1998-2003 and 2003-2008 Australian Health Care Agreements for funding public hospitals, improving public reporting on health system performance, and reforming the interface of acute and aged care services. Dr Willcox was involved in the policy development for the National Health Strategy in the early 1990s on issues including new funding models for general practice. s 47F

National Health and Hospitals Reform Commission

Terms of Reference

Australia's health system is in need of reform to meet a range of long-term challenges, including access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies generated by blame and cost shifting, and the escalating costs of new health technologies.

The Commonwealth Government will establish a National Health and Hospitals Reform Commission to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term, to address these challenges.

1. By April 2008, the Commission will provide 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.
2. By June 2009, the Commission will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to:
    a. reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing;
    b. better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;
    c. bring a greater focus on prevention to the health system;
    d. better integrate acute services and aged care services, and improve the transition between hospital and aged care;
    e. improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;
    f. improve the provision of health services in rural areas;
    g. improve Indigenous health outcomes; and
    h. provide a well qualified and sustainable health workforce into the future

The Commission's long-term health reform plan will maintain the principles of universality of Medicare and the Pharmaceutical Benefits Scheme, and public hospital care.

The Commission will report to the Commonwealth Minister for Health and Ageing, and, through her to the Prime Minister, and to the Council of Australian Governments and the Australian Health Ministers' Conference.

The Commonwealth, in consultation with the States and Territories from time to time, may provide additional terms of reference to the Commission.

The Commission will comprise a Chair, and between four to six part-time commissioners who will represent a wide range of experience and perspectives, but will not be representatives of any individual stakeholder groups.

The Commission will consult widely with consumers, health professionals, hospital administrators, State and Territory governments and other interested stakeholders.

The Commission will address overlap and duplication including in regulation between the Commonwealth and States.

The Commission will provide the Commonwealth Minister for Health and Ageing with regular progress reports.

Attachment C

National Health and Hospital Reform Commission Interim Report: *A Healthier Future for all Australians*

The NHHRC was established on 25 February 2008 to develop a long-term health reform plan for a modern Australia. The interim report is a work in progress and contains the Commission's thinking on the challenges facing the health system now and in the future, as well as indicative directions for long term reform. Following the release of the report, the Commission will seek feedback and undertake further consultations, particularly with the states and territories (the states), to guide the preparation of the final report which is due at the end of June 2009.

The report is structured around four themes:

- Taking Responsibility – individual and collective action to build good health and well-being – by people, families, communities, health professionals, employers and governments (Chapter 1);
- Connecting Care- Comprehensive care for people over their lifetime (Chapters 2 - 7);
- Facing Inequities- recognise and tackle the causes and impacts of health inequities (Chapters 8 - 11); and
- Driving quality performance - Better use of people, resources, and evolving knowledge (Chapters 12 - 15).

The report contains 116 directions for reform. In our analysis of the report we have identified the reform directions that propose new, major reform, and are likely to generate the most discussion and debate. These include:

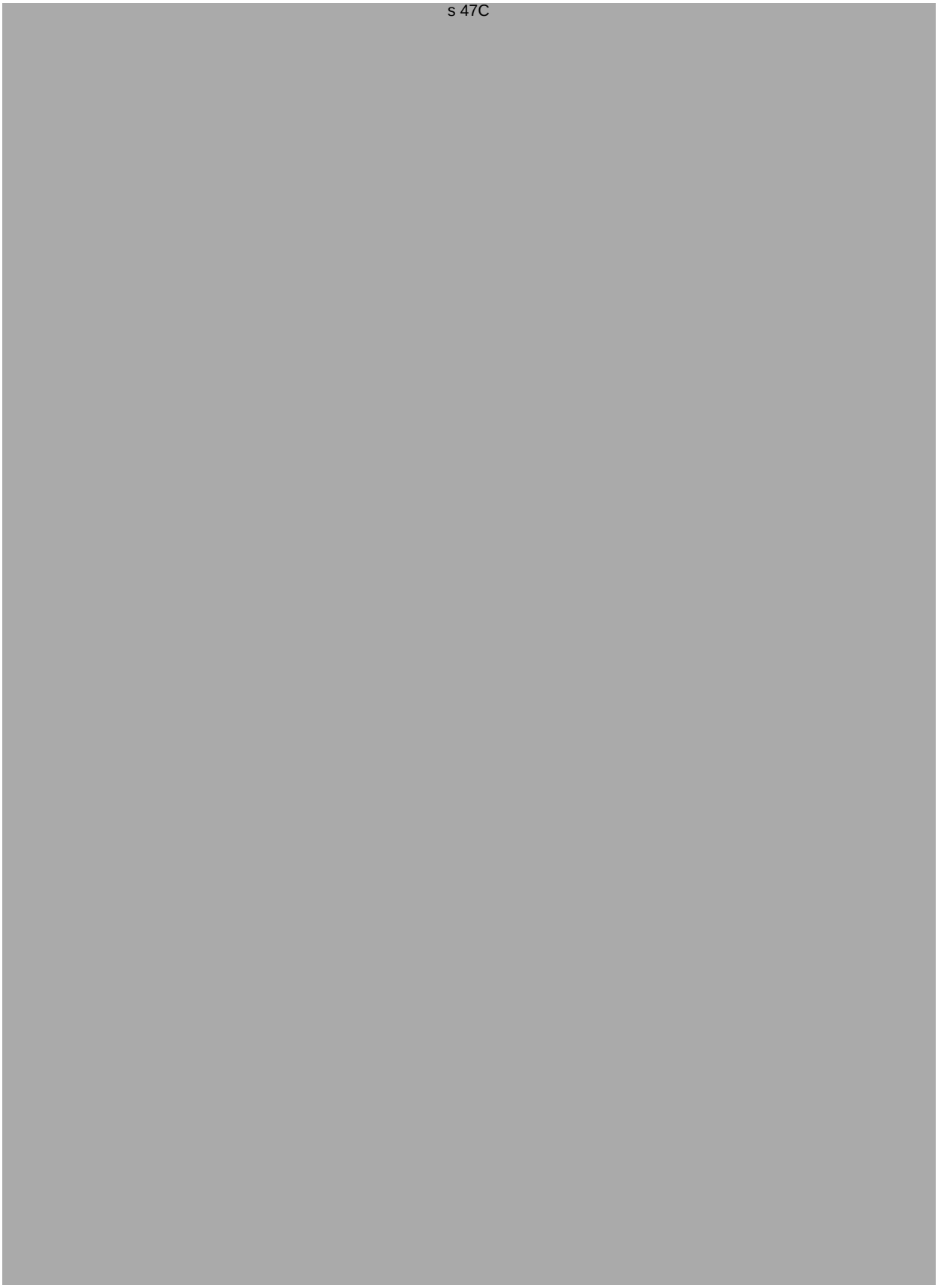
1. **Reform options for governance**
2. **Primary Health Care service reform**
3. **Universal access to dental services funded through a Medicare Levy**
4. **Aged Care funding model: person (or voucher) based rather than place based**
5. **A National Aboriginal and Torres Strait Islander Health Authority to purchase services under an Indigenous-specific schedule**

1. Reform options for governance

Drawing on the diversity of views expressed through submissions and consultations, the Commission outlines three major possible approaches to improving governance of the Australian health system. s 47C

s 47C

s 47C

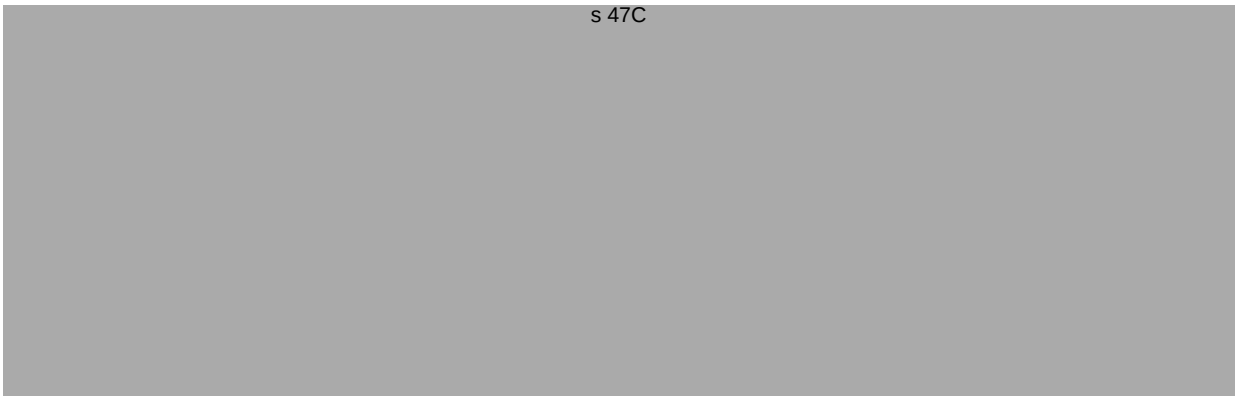


2. Primary Health Care Service Reform

Chapter 2 of the report focuses on primary health care services. To better integrate and strengthen primary health care, the Commission proposes that the Commonwealth assumes responsibility for all primary health care policy and funding. As part of its expanded role, the Commission proposes the Commonwealth encourage the establishment of Comprehensive Primary Health Care Centres (discussed at Attachment D) and that young families and

people with chronic and complex conditions have the option of enrolling with a single primary health care centre to improve care. The Commission also proposes workforce role and funding redesign, commencing in rural and remote areas, which would see Medicare rebates applying to some diagnostic services and specialist medical services ordered or referred by nurse practitioners and other registered health professionals, as well as expanded Pharmaceutical Benefits Sschedule referral rights.

s 47C



3. **Universal access to dental services funded through a Medicare Levy**

The Commission proposes that Australia should have a scheme, 'Denticare Australia', for universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay. Denticare Australia would be based on a mixed approach of public and private cover, with the additional costs funded by an increase in the Medicare Levy of 0.75 per cent of taxable income.

s 47C

4. **Aged Care funding model: person (or voucher) based rather than place based**

The Commission proposes reform to the Aged Care funding model to link funding more directly to people rather than places. Several measures are proposed to increase competition between aged care providers and improve efficiency and consumer choice. These include the removal of restrictions on the number of Commonwealth funded residential aged care places individual providers can offer, while maintaining limits on the total number of funded places within large planning regions ("person-based" funding); allowing accommodation bonds to be paid in high-level residential care, provided that person-based funding has first increased competition in supply and pricing; streamlining and integrating aged care programs to reduce complexity and improve consistency of fees and eligibility criteria; greater consumer choice in the way care is delivered; and improving the availability of information about aged care services and quality.

s 47C

5. **A national Aboriginal and Torres Strait Islander Health Authority to purchase services under an Indigenous-specific schedule**

Under this reform direction, the Commission proposes the establishment of a National Aboriginal and Torres Strait Islander Health Authority to purchase services specifically for Indigenous Australians and their families as a mechanism for 'closing the gap'. The Authority would operate in much the same way as the Repatriation Commission/Department of Veterans' Affairs does for the veteran community. Indigenous people would need to register to receive services funded through the Authority. Registration would be voluntary, and those not registered would still be covered by existing Medicare arrangements.

s 47C

Attachment D

National Health and Hospital Reform Commission Interim Report – Alignment with current government policy and reform processes.

A number of the reform directions proposed by the Commission are aligned with the government's current health reform agenda and the package of reform measures to the health and hospital system agreed at the 29 November 2008 COAG meeting. In our analysis of the report we have identified some of the key areas of alignment which are:

1. **Comprehensive Primary Health Care Centres**

The Commission proposes, as a key feature of primary health care reform, the establishment of Comprehensive Primary Health Care Centres (Centres) which align closely with GP Super Clinics. The Centres are designed to provide a range of services to become a 'one-stop-shop' for medical and non-medical services including general practitioners, nursing services and secondary and allied care. Similarly, GP Super Clinics are intended to bring together general practitioners, nurses, visiting medical specialists, allied health professionals and other health care providers. Whereas general practitioners are the key element of each GP Super Clinic, the emphasis on general practitioner led teams is less in the Centre proposal: it is assumed that all services provided at Centres would work together in partnership to treat patients.

The Commonwealth has already committed $275 million over five years from 2007-08 to establish 31 GP Super Clinics across Australia. Under the Commission's proposal, the government would encourage the establishment of centres through an offer of initial fixed capital grants on a competitive basis. To be eligible for this funding, the Commission proposes there would need to be demonstrated involvement of medical and allied health providers and community participation in planning. This is much the same as the process for GP Super Clinics, however the government selected the sites for establishment.

As part of primary health care reform, the Commission proposes that the Commonwealth would become responsible for all government funding of all primary health care services including state and territory and non government services such as generalist community health centres. These services would be part of the proposed Centres. Under the current GP Super Clinics model, community health services continue to be funded by State and Territory Governments but are integrated with Commonwealth funded services such as general practice, without the requirement for Commonwealth control of all primary health care funding.

2. **Preventive Health Agency**

The Commission propose a comprehensive agenda of preventive health measures and the establishment of an independent national Agency for health promotion and prevention. This agenda aligns closely with the government's current focus on preventive health and the National Partnership Agreement on Preventive Health (Preventive Health NP). The Agency proposed by the Commission would be responsible for national leadership on the development of a series of ten-year 'Healthy Australia Goals', based on the Healthy Australia 2020 goals with regular reporting by governments on progress. It would also be responsible for building an evidence base for the value of health promotion and prevention, undertaking social marketing and educational campaigns, leading cross-sectoral action on health promotion and prevention and developing any capacity and infrastructure that is required so that prevention becomes the platform of healthy communities and is integrated into all aspects of the health care system.

Similarly, the Preventive Health NP establishes the National Preventive Health Agency to lay the foundation for healthy behaviours through funding social marketing efforts and programs supporting healthy lifestyles, and subsequently developing policy and infrastructure to support these efforts. It will also have a research and surveillance role and conduct a workforce audit and develop associated strategy to identify any gaps in preventative health and options to resolve them.

The Commonwealth has committed $872.2 million to 2015 to preventive health through the Preventive Health NP which focuses on healthy children, workers and communities.

The Commission also notes that the National Preventative Health Taskforce is currently undertaking work on healthier choices in relation to obesity, tobacco and alcohol, and assumes that this Taskforce will operate in parallel to the Agency on these issues.

The Commission also proposed the inclusion of Health Literacy as part of the national curriculum for primary and secondary students, and proposed that this would form part of the national skills assessment process. This is not something that the Preventative Health NP addresses.

3. **Workforce Agency**

The Preventive Health NP allocates funding for the creation a National Health Workforce Agency to establish more effective, streamlined and integrated clinical training arrangements and supports workforce reform initiatives. This Agency has responsibility for funding, planning and coordinating clinical training for undergraduates in medicine, nursing, allied health and dental, as well as supporting research and planning, and progressing new workforce models and reforms. Similarly, the Commission suggests the establishment of a National Clinical Education and Workforce Training Agency (Clinical Education Agency), which builds further on the Preventive Health NP Agency. The Commission suggests that the Clinical Education Agency's key role would be national workforce planning to identify future skill needs to assist in the allocation of education and training funding, as well as to identify and facilitate the up skilling of health professionals in areas of workforce shortage, and to identify gaps in specialist medical training. The Commission notes that the National Health Workforce Taskforce is working in this area, but makes no mention of the National Health Workforce Agency established by COAG.

The Commonwealth has committed $1.1 billion over four years for health workforce and infrastructure initiatives. In addition, the states and territories have committed $175.6 million over for years to progress clinical undergraduate training.

The Commission also suggests a national registration process for health professionals. The report proposes that this process will build on the COAG national registration initiative for physiotherapy, optometry, nursing and midwifery, chiropractic care, pharmacy, dental care, medicine, psychology and osteopathy.

In addition to funding undergraduate clinical training in medicine, nursing, allied health and dental, as the current National Health Workforce Agency will do, the Commission proposes clinical education placements for postgraduate students, as well as partnerships with universities and vocational education facilities.

4. **Activity Based Funding**

Activity based funding is a reform that is consistently raised throughout the Commission's report, primarily in relation to all hospital provided services, but also in relation to sub-acute care services and Aboriginal and Torres Strait Islander health services. The Commission proposes the use of activity based funding for both public and private hospitals using casemix classifications for both inpatient and outpatient treatment, emergency department services and sub-acute services.

The National Partnership in Hospitals and Health Workforce Reform (Hospitals and Health NP) includes investment in activity based funding of $154 million over five years contributed by the Commonwealth and states and territories, and will allow for the development and application of nationally consistent activity classifications (casemix), and the collection of data on public hospital activity, including acute, sub-acute, emergency department, outpatients and hospital based community health services. It will also deliver development and application of nationally consistent cost modelling of hospital activity to enable activity costs to be determined across the sector.

The Commission has also proposed performance related payments in addition to activity based funding. They suggest that performance payments should relate to outcomes or process associated with clinical quality and the quantum of improvement compared to an evidence base, best practice target or measured outcome. Performance payments will complement activity based funding.

Document 2

Australian Government
Department of the Prime Minister and Cabinet

MB09/13

Prime Minister (for meeting)

Secretary
Mr Tune
Ms Wilson
Mr English
Ms Cass
s 22(1)(a)(ii)
Dr Philip
Mr Jordan
Mr Kumar
Mr Fredericks

[File LA]

Briefing by Minister Roxon and the National Health and Hospitals Reform Commission (NHHRC) on the NHHRC Interim Report

Purpose: To discuss the NHHRC's Interim Report - *A Healthier Future for all Australians*	**Timing:** TBA

Our Objectives (Agenda and Talking points are at Attachment A.)

- To seek further information from the Commission on the major reform areas in the interim report.

s 47C

Their Objectives (Attendees/Commission Terms of Reference are at Attachment B.)

- To provide a briefing on the NHHRC's Interim Report.

Key Matters

The report is structured around four themes and contains a number of reform directions. An overview of the report and the areas of major reform is provided at Attachment C. Attachment D discusses the areas where the report aligns with current government policy and reform processes.

Primarily, the discussion will be focussed on two major reform areas:

1. Reform options for governance:
   - Option A: Commonwealth takes responsibility for primary health policy and funding. States and territories funded for public hospitals according to activity based funding.
   - Option B: Commonwealth to be solely responsible for all aspects of health care, delivering through regional health authorities.
   - Option C: Commonwealth to be solely responsible for all aspects of health and health care, establishing compulsory social insurance to fund local delivery.
2. Primary Health Care Service reform, including:
   - Commonwealth takeover of all primary health care policy and funding;
   - Voluntary enrolment with primary health providers for chronic, complex and special needs patients; and
   - Workforce roles and funding redesign.

The report will be launched at the National Press Club on 16 February 2009.

Attachments

A. Talking Points/Agenda
B. Attendance/Biographies
C. Overview of Report
D. Alignment with current policy and reform

Yael Cass
Assistant Secretary
22 January 2009

NOTED
Noted by PM – follow up matter (ref on health literacy in the curriculum) discussed with Yael Cass.
Kevin Rudd
Date: s 22(1)(a)(ii)

QA: s 22(1)(a)(ii)

Contact Officer: s 22(1)(a)(ii)

25/2/09

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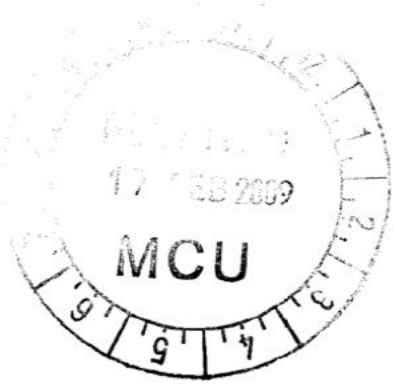
Document 3

Australian Government

National Health and Hospitals Reform Commission

16 February 2009



The Hon K. M. Rudd MP
Prime Minister
Parliament House Canberra

Dear Prime Minister,

As Chair of the National Health and Hospitals Reform Commission (NHHRC), I am pleased to present you with a copy of the Commission's Interim Report, *A Healthier Future for all Australians.*

This report is the product of months of consultations, research and deliberations by the Commission, and contains policy directions for reform to strengthen and improve our health system to serve this and future generations of Australians.

We will further discuss our policy directions for long-term health reform with governments, the health sector and the Australian community over the coming months as we prepare our final report, to be completed by June 2009.

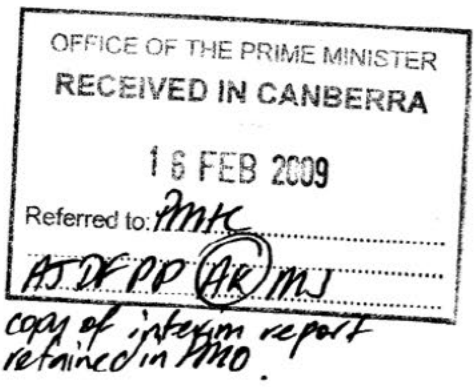
If you would like to know more about the work of the Commission or wish to comment on our Interim Report, please send us your feedback via talkhealth@nhhrc.org.au

There are other ways for you, your colleagues or your constituents to provide feedback to the NHHRC, including an electronic online survey. All the details are on our website at www.nhhrc.org.au

Yours sincerely

s 22(1)(a)(ii)

Dr Christine Bennett
Chair
National Health and Hospitals Reform Commission



Document 4

Australian Government
Department of the Prime Minister and Cabinet

Prime Minister (for meeting)

Secretary
Mr Tune
Mr Rimmer
Ms Cass
Dr Banerjee
s 22(1)(a)(ii)

Mr Jordan
Mr Fredericks
Mr Davidoff
Mr Kumar

File JN

Meeting With the National Health and Hospitals Reform Commission (NHHRC)	
Purpose: To discuss the NHHRC Final Report (due 30 June 2009)	**Timing:** 6pm – 7pm, Tuesday 23 June 2009 **Venue: TBA**

Our Objectives (Talking points are at Attachment A.)

- To seek further information from the Commission on the final recommendations that will be coming forward as part of their final report (due 30 June 2009).

Their Objectives (Membership and terms of reference are at Attachment B.)

- To provide a briefing on the Commission's final report and the key recommendations.

Key Matters

- It is expected that the Commission's final report will largely recommend the 116 reform directions outlined in their interim report.
- In terms of governance, it is anticipated that the Commission will provide a recommendation on governance of health and hospitals, along the lines of Option A, which the interim report outlined as: Commonwealth takes responsibility for primary health policy and funding, with states and territories to be funded for public hospitals according to activity based funding.
- An overview of the governance options contained in the interim report is at Attachment C.
- PM&C has convened a Secretaries Taskforce on Health Reform (PM&C, Treasury, Finance and Health are represented) which had its inaugural meeting on 22 June 2009. The Taskforce, supported by a working group, will oversee the work, including an s 47C submission, leading to the public release of the Commission's final report. An overview of the process, in line with your preferred strategy, is at Attachment D.

s 47C

Attachments
A:Talking Points
B: Membership and ToR
C: Governance Options
D: Overview of the Process

s 22(1)(a)(ii)
A/g Assistant Secretary
Health and Ageing Branch
22 June 2009

NOTED

Kevin Rudd

Date:

QA s 22(1)(a)(ii)

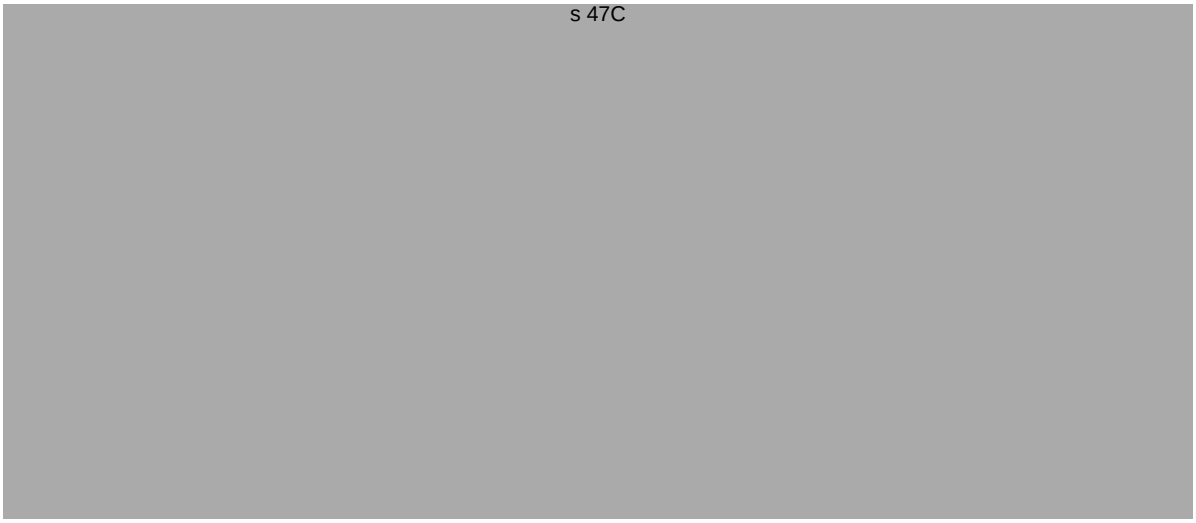
Contact Officer: s 22(1)(a)(ii)
Consultation: Strategy and Delivery Division

Background
You met with the Commission on 6 February 2009 to discuss the Interim Report.

Attachment A: Talking Points

General Questions

s 47C

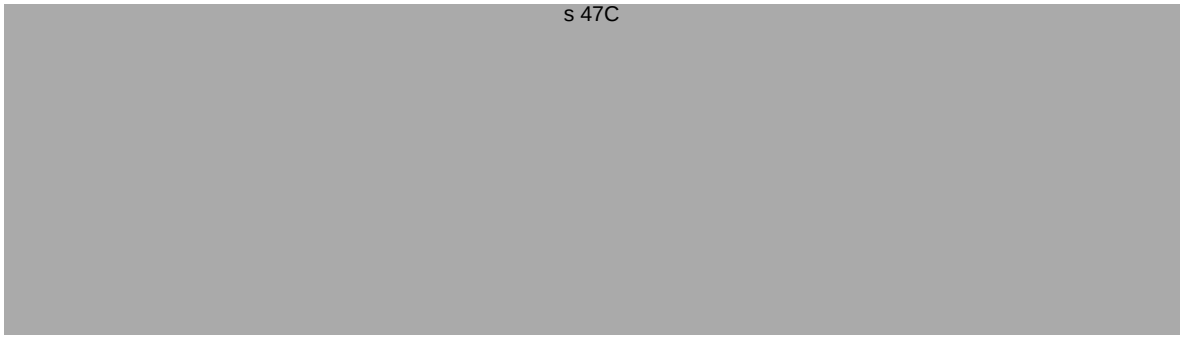


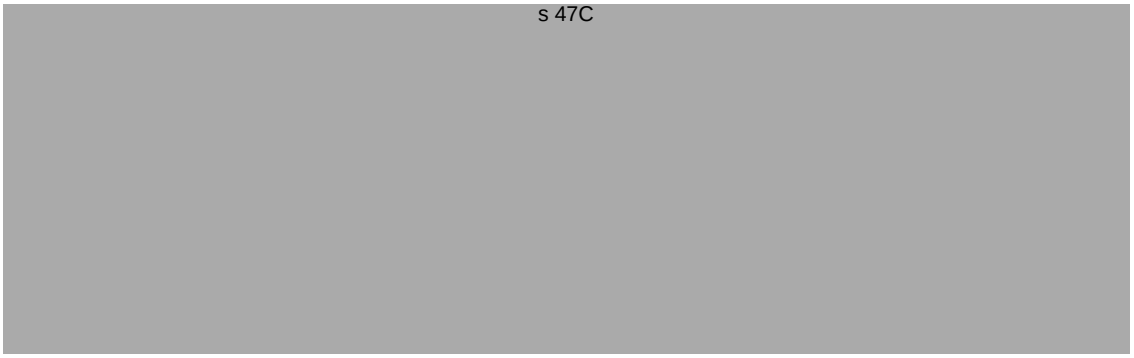
Governance Options- Hospitals

s 47C

Primary Care

s 47C




s 47C

Attachment B: Membership and Terms of Reference

Dr Christine Bennett, Chair of the National Health and Hospitals Reform Commission is the Chief Medical Officer of BUPA Australia Ltd, operating as MBF, HBA and Mutual Community. At the time of her appointment as Chair of the Commission, Dr Bennett was Group Executive, Health and Financial Solutions, and Chief Medical Officer of MBF Ltd. Dr Bennett is a trained paediatrician and a Fellow of the Royal Australasian College of Physicians. She was Head of Health Services Planning in NSW Health and worked with Professor Shearman to lead a major reform of maternity services in that state, negotiated the relocation of the Children's Hospital to Westmead, and implemented the NSW State Trauma Plan. She was subsequently the General Manager of the Royal Hospital for Women, and then Chief Executive of Westmead Hospital and Community Health Services. s 47F [redacted]

The Hon Dr Geoff Gallop AC is Professor, Director, Graduate School of Government, University of Sydney. Professor Gallop was the Premier of Western Australia from 2001 to 2006. He was a Minister in the Lawrence Labor Government from 1990 to 1993 (holding a range of portfolios most notably Education, Fuel and Energy and Minister Assisting the Treasurer) and when that Government was defeated in 1993 he took up a range of Shadow Ministerial appointments. In 1994 he was elected Deputy Leader of the State Parliamentary Labor Party and in 1996 he was elected Leader.

As Premier, he oversaw a range of political and social reforms (electoral reform, gay and lesbian equality and a State Administrative Tribunal), upgraded the State's industrial and labour laws, brought a spirit of reconciliation to the resolution of Native Title and developed partnership models for the State's indigenous communities, changed the law to require all 16 and 17 year olds to be in education or training, was the first Premier to commit his government to a major desalination plant, stopped the logging of all of the State's Old Growth Forests creating record numbers of new national parks, restructured the State's electricity and racing industries, and started construction of the Perth to Mandurah Railway and City Tunnel.

Dr Mukesh Haikerwal is a General Medical Practitioner in Melbourne's Western Suburbs where he has practised for over 17 years. He was the 19th National President of the Australian Medical Association in 2007 following 2 years as National vice president and 2 years as Victorian State President.
He is currently working with the National e-Health Transition Authority appraising the clinical health professional community of the benefits of vital role of IT in healthcare. Internationally, he is the Chair of the World Medical Association Finance and Planning Committee.

Professor Justin Beilby is the Executive Dean, Faculty of Health Sciences, which oversees training for medical, dental, nursing, psychology and health sciences graduates at University of Adelaide. Professor Beilby is also a Professor of General Practice at the University of Adelaide.

Professor Beilby has been in general practice in both rural and urban settings for over twenty years. He has been President of the Australian Association for Academic General Practice, and a member of the Strategic Research Initiative Working Group of the NHMRC. Professor Beilby has had a long career in general practice and primary care research, particularly in the areas of financing, chronic disease management, health services reform and quality initiatives.

Dr Stephen Duckett is Chief Executive of the Centre for Healthcare Improvement in Queensland Health, responsible for clinical governance, leadership transformation, health statistics and public reporting and improving hospital access (elective surgery, emergency department care, outpatients) across Queensland. Dr Duckett was formerly (1996 to 2005) Professor of Health Policy and Dean of the Faculty of Health Sciences at La Trobe University. Dr Duckett's research and publications focus on aspects of the Australian health care system (including health insurance, workforce), the economics of hospital care (particularly the use of casemix measures), and safety and quality of hospital care.

From 1994 to 1996, he was Secretary of the Commonwealth Department of Human Services and Health. From 1983 to 1993, he held various operational and policy positions in the Victorian Department of Health and Community Services and its predecessors, including Director of Acute Health Services, in which position he was responsible for designing and implementing Victoria's casemix funding policy. From 2000 to 2005, Dr Duckett chaired the boards of directors of Bayside Health and the Brotherhood of St Laurence. He is an Adjunct Professor at the University of Queensland and Griffith University.

Sabina Knight is a remote area nurse and Associate Professor in Remote Health Practice and Remote Health Management at the Centre for Remote Health in Alice Springs. Associate Professor Knight's professional activities have been focused on remote, isolated and rural health, in particular Aboriginal primary health care and health inequalities, and she is a recognised leader in remote health nationally and internationally. Associate Professor Knight was a foundation member, and past president, of the Council of Remote Area Nurses of Australia (CRANA), foundation deputy Chair and Chair of the National Rural Health Alliance (NRHA), and Chair of Central Australian Rural Practitioners Association (CARPA) editorial committee producing the internationally recognised CARPA best practice guidelines for remote practitioners.

The Hon Rob Knowles AO is currently Chair of the Mental Health Council of Australia. Mr Knowles is a consultant /adviser in the health sector and has a very high level of expertise in the field of public administration, having been a senior Minister in the Victorian Government for seven years including Minister for Health.

Ms Mary Ann O'Loughlin is Executive Councillor and Head of the Secretariat of the COAG Reform Council. Before she joined the Council in 2008, Ms O'Loughlin had 20 years senior executive experience in both the public and corporate sectors. Formerly a Director of the Allen Consulting Group, a leading economics and public policy consulting firm, Ms O'Loughlin specialises in health and social policy analysis and development. She was Senior Adviser (Social Policy) to the then Prime Minister, the Hon Paul Keating, and held a number of senior positions in the Commonwealth Public Service, including Deputy Secretary of the Department of Employment, Education, Training and Youth Affairs, and First Assistant Secretary, Social Policy, Department of Prime Minister and Cabinet. Ms O'Loughlin has also worked as a senior executive for a major publicly listed health care company.

Professor Ronald Penny AO is one of Australia's leading immunologists and is currently Emeritus Professor of Medicine, University of NSW; and Senior Clinical Advisor, NSW Health. He was Director, Centre for Immunology at St Vincent's Hospital and University of NSW until 2002. He is currently the Co-Chair of the NSW Chronic Aged Community Health Priority Taskforce. Professor Penny was in 1979 awarded the first Doctor of Science for clinical research from the University of NSW, followed by a Personal Chair in clinical immunology in 1998.

Professor Penny has published over 350 medical and scientific papers in prestigious national and international journals. Professor Penny was previously the Co-Chair the NSW State Government's Chronic and Complex Care Implementation Advisory Group; Chairman of the NSW Blood Products Advisory Committee; Chairman of the NSW SARS Task Force, and the Ministerial Advisory Council on Medical and Health Research. Professor Penny has served

as Honorary Consultant at many Sydney hospitals and was a member of the Editorial Boards of a number of leading international journals.

Dr Sharon Willcox is the Director of Health Policy Solutions, an independent health consulting company. She has over 25 years experience working in health policy in government and the community sector.

Her government experience in the Victorian, New South Wales and Commonwealth health departments has included a leading role in the negotiations of the 1998-2003 and 2003-2008 Australian Health Care Agreements for funding public hospitals, improving public reporting on health system performance, and reforming the interface of acute and aged care services. Dr Willcox was involved in the policy development for the National Health Strategy in the early 1990s on issues including new funding models for general practice. s 47F

National Health and Hospitals Reform Commission

Terms of Reference

Australia's health system is in need of reform to meet a range of long-term challenges, including access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies generated by blame and cost shifting, and the escalating costs of new health technologies.

The Commonwealth Government will establish a National Health and Hospitals Reform Commission to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term, to address these challenges.

1. By April 2008, the Commission will provide 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.
2. By June 2009, the Commission will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to:
    a. reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing;
    b. better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health;
    c. bring a greater focus on prevention to the health system;
    d. better integrate acute services and aged care services, and improve the transition between hospital and aged care;
    e. improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness;
    f. improve the provision of health services in rural areas;
    g. improve Indigenous health outcomes; and
    h. provide a well qualified and sustainable health workforce into the future

The Commission's long-term health reform plan will maintain the principles of universality of Medicare and the Pharmaceutical Benefits Scheme, and public hospital care.

The Commission will report to the Commonwealth Minister for Health and Ageing, and, through her to the Prime Minister, and to the Council of Australian Governments and the Australian Health Ministers' Conference.

The Commonwealth, in consultation with the States and Territories from time to time, may provide additional terms of reference to the Commission.

The Commission will comprise a Chair, and between four to six part-time commissioners who will represent a wide range of experience and perspectives, but will not be representatives of any individual stakeholder groups.

The Commission will consult widely with consumers, health professionals, hospital administrators, State and Territory governments and other interested stakeholders.

The Commission will address overlap and duplication including in regulation between the Commonwealth and States.

The Commission will provide the Commonwealth Minister for Health and Ageing with regular progress reports.

Attachment C: Interim Report Governance Options

Interim Report Reform Options

The interim report presented three reform options on governance of the health system for consultation and debate:

Option A - shared responsibility with clearer accountability. the Commonwealth would takeover primary health care policy and funding. States and territories would remain responsible for public hospitals and Commonwealth funding would be allocated in the following way:

- a significant proportion per episode of the efficient costs of inpatient treatment and of emergency department treatment (set at 40 per cent); and
- Paying using a casemix classification, 100 per cent of the efficient costs of delivery of hospital outpatient treatments.
- The Commonwealth contributing a fixed percentage of the efficient cost of admitted patient services (activity based funding) within a more comprehensive coverage of component hospital costs such as inclusion of capital and indirect costs within the ABF model.

s 47C

Option B – Commonwealth to be solely responsible for all aspects of health care, delivered through regional health authorities. Under this option all responsibility for public funding, policy and regulation would be transferred to the Commonwealth and regional authorities would take over the majority of the state government funded health services within each region.

s 47C

Option C - Commonwealth to be solely responsible for all aspects of health and health care, establishing compulsory social insurance to manage distribution of funds for local delivery. Under this option, the Commonwealth would establish a tax funded community insurance scheme under which people would choose from multiple, competing public or private sector health plans. The plans would cover a mandatory set of services including, hospital, medical, pharmaceutical and allied health services. Aspects of the regulatory regime would be similar to those for current private health insurance, but the health plans would have responsibility for all health cover for their members. People would have choice, but would be required to be enrolled with a health plan. Funding would be raised via a health levy to meet the full costs of the social insurance scheme. Implementation of the option would change the current conception of universal access to health care.

s 47C

s 47C [redacted]

Attachment D: Process for Responding to the NHHRC Final Report

Process for responding to the final NHHRC report

A Secretaries Taskforce from PM&C, DHA, DoFD and Treasury has been established to oversee preparations for the initial response to the final NHHRC report. A joint working group from these agencies has also been established in PM&C to prepare the response.

s 34(3)

An overview of the workplan is at Attachment D1.

s 47C

THE HON NICOLA ROXON MP
MINISTER FOR HEALTH AND AGEING

The Hon Kevin Rudd MP
Prime Minister
Parliament House
CANBERRA ACT 2600

Dear Prime Minister

I am writing to seek your approval to the extension of Dr Christine Bennett's appointment as Chair of the National Health and Hospitals Reform Commission (NHHRC). The extension sought is for three months to enable her to attend to Commission-related activities in the aftermath of the final report, once it is provided to the Government by 30 June 2009, and its eventual release after Government consideration.

The NHHRC was established in February 2008 and there is a ten person board chaired by Dr Bennett. The NHHRC was tasked with providing advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long-term, to address the challenges of access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies generated by blame and cost shifting, and the escalating costs of new health technologies.

Currently, Dr Bennett's term is set to expire on 30 June 2009; the same date the NHHRC's final report is due to me. There may be some tasks for Dr Bennett to undertake in her role as Chair of the NHHRC in the period following the delivery of the final report. In addition, Dr Bennett has been invited to attend several functions in her role as Chair of the NHHRC which are scheduled after 30 June 2009.

Yours in friendship

s 22(1)(a)(ii)

NICOLA ROXON

23 JUN 2009

Parliament House Canberra ACT 2600 • Telephone: (02) 6277 7220 Facsimile: (02) 6273 4146

s 22(1)(a)(ii)

Document 6

DEPARTMENT OF THE PRIME MINISTER AND CABINET

Ref: C09/33844

To: Parliamentary Secretary to the Prime Minister (for decision)

PSPM
Ms Stalder

PMO
Mr Kumar

File (CJ)

PM&C
Secretary
Mr Tune
Ms Case
Mr English
s 22(1)(a)(ii)

Re: **Extension of Dr Christine Bennett's appointment as Chair of the National Health and Hospitals Reform Commission (NHHRC)**

Urgency:	Timing:	Initiation:
High	Decision required by 29 June 2009	MO

Recommendations: That you:

1. **agree to extend Dr Bennett's tenure as Chair of the NHHRC for six months; and** — **Agreed / Not Agreed**
2. **sign the attached letter to Minister Roxon.** — **Signed / Not Signed**

s 22(1)(a)(ii)

Anthony Byrne **Date:** 28/6/09

PM&C ASSESSMENT:

The reasons for the recommendations presented are:

- Dr Bennett's term as Chair of the NHHRC is set to expire on 30 June 2009, the same date as the final NHHRC report is due to the Minister for Health and Ageing.
- It is likely there will be tasks for Dr Bennett to undertake in her role as Chair of the NHHRC in the period following delivery of the final report, including attending several functions.
- It is understood that the Prime Minister invited Dr Bennett to participate in a six month national consultation process following the public release of the report.

If accepted you may see:

- Dr Bennett's term as Chair of the NHHRC extended for six months. During this time it is likely that she will represent the NHHRC.

The initiatives may be considered successful when the following is observed:

- Nil.

The following sensitivities should be noted:

- Nil.

The financial implications of these recommendations are:

- Dr Bennett receives remuneration for her role as Chair of the NHHRC. s 47F s 47F

Attachments:

a) Response to the Minister for Health and Ageing
b) Incoming correspondence from the Minister for Health and Ageing

Signed	Contact officer: s 22(1)(a)(ii)	
s 22(1)(a)(ii) A/g Assistant Secretary Health and Ageing 26 June 2009	Consultation: Details of consultation QA:	

s 22(1)(a)(ii)

Document 7

THE HON ANTHONY BYRNE MP
PARLIAMENTARY SECRETARY
TO THE PRIME MINISTER
CANBERRA

Reference: C09/33844

The Hon Nicola Roxon MP
Minister for Health and Ageing
Parliament House
CANBERRA ACT 2600

29 JUN 2009

Dear ~~Minister~~ Nicola

Thank you for your letter of 23 June 2009 to the Prime Minister regarding an extension of Dr Christine Bennett's appointment as Chair of the National Health and Hospitals Reform Commission (NHHRC). The Prime Minister has asked me to reply on his behalf.

Following their meeting on 23 June, I understand that the Prime Minister has invited Dr Bennett to participate in a six month national public consultation process following the public release of the NHHRC report. As such, I think it appropriate that Dr Bennett's appointment is extended for six months, to 31 December 2009.

Other members of the NHHRC may need to be co-opted to participate in the consultation process as required.

Yours sincerely

s 22(1)(a)(ii)

Anthony Byrne

To: Prime Minister (for information)

PMO
Mr Jordan
Mr Kumar
File

PM&C
Secretary
Mr Tune
Mr Rimmer
Ms Cass
Mr Banerjee
s 22(1)(a)(ii)

Re: National Health and Hospitals Reform Commission (NHHRC): A Healthier Future for all Australians, Final Report June 2009.

Urgency:	**Timing:**	**Initiation:**
High	Nil.	Department

Recommendations: That you note the key recommendations of the Commission's report and PM&C's preliminary analysis of the recommendations attached.

Kevin Rudd **Date:**

PM&C ASSESSMENT:

The reasons for the recommendations presented are:

- The NHHRC has presented its final report to government on health reform.
- PM&C has considered the report's recommendations and considers that the key recommendations are:
  - A Healthy Australia Accord – the Commonwealth would take full responsibility for the policy and public funding of primary health care, basic dental care, Indigenous health and aged care. Funding for public hospitals through the use of ABF at 100 per cent of the efficient costs of public hospital outpatient services and 40 per cent of the cost of care for every episode of acute care and subacute care for public inpatients and emergency department treatment.
  - Medicare Select – in the long term the Government should consider becoming the sole government funder of health services.
  - The introduction of Denticare Australia.
  - In aged care, funding people instead of places.
  - A national Aboriginal and Torres Strait Islander Health Authority to purchase services under an Indigenous-specific schedule

s 47C

[redacted]

s 22(1)(a)(ii)

s 22(1)(a)(ii)

s 22(1)(a)(

- PM&C has convened a Secretaries Taskforce on Health Reform (PM&C, Treasury and Finance) which had its inaugural meeting on 22 June 2009. The Taskforce, supported by a working group, will oversee central agency work on health reform, s 34(3) [redacted]

The financial implications of these recommendations are:

- The cost of the NHHRC recommendations is between $2.8 billion and $5.7 billion in recurrent costs in a full year and between $4.3 billion and $7.3 billion in capital cost over five years. This includes estimated savings from the introduction of Activity-Based Funding in public hospitals of between $570 million and $1.3 billion per annum.
- s 47C [redacted]

Attachments:

A. PM&C analysis of the National Health and Hospitals Reform Commission: A Healthier Future for all Australians, Final Report June 2009.

Ref: B09/1063

Attachment A - PM&C ANALYSIS OF THE NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION: A HEALTHIER FUTURE FOR ALL AUSTRALIANS, FINAL REPORT JUNE 2009.

The Australian health system: problems and challenges

The Commission begins its report with an assessment of the Australian health system, which by most comparisons is very strong, with health outcomes among the best in the world. Despite the strengths of the system, the Commission acknowledges that it is a system under pressure and out of balance. Through its consultations and work, the Commission identified the following concerns:

1. The system is out of balance, there is :
    - a focus on illness at the expense of wellness;
    - a growing tension between private and public provision;
    - a provider focus, rather than patient focus; and
    - a disjunction between service provision, teaching and research.

2. There are inequities in access and outcomes, evident by:
    - The life expectancy gap for Aboriginal and Torres Strait Islander peoples
    - People living with mental illness are poorly supported
    - Remoteness leads to poorer health outcomes
    - Basic dental care is unaffordable for many Australians

3. Inefficiencies in the organisation and delivery of health care:
    - Variation in hospital costs per patient
    - Primary care delivery could be more efficient
    - Older patients in public hospitals often need a different form of care
    - Aged care services could be made more efficient
    - Inefficient processes existing within health care could be reduced

4. There are growing concerns about safety and quality:
    - Action is needed to measure and prevent adverse events
    - Poor capture and use of performance data
    - Potentially preventable hospital stays

Underlying these concerns is a system which is fragmented with a complex division of funding responsibilities and performance accountabilities between different levels of government. This fragmentation and complexity causes confusion, the system is difficult to navigate leading to uneven access and cost and blame and service shifting by providers.

The Commission also sets out the future challenges for our health system, which can be summarised as:

- The rising cost of health care
- Demographic trends (such as an ageing population)
- Workforce shortages and declining morale
- Chronic health conditions are more prevalent than ever before
- Advances in health technology and information and communications technology.

It is the Commission's view that now is the time for reform and it outlines its framework for health care reform described as an agile, self-improving, and sustainable health system which puts the health and wellbeing of people and families firmly at its centre.

The NHHRC's vision for long-term health reform

The Commission identifies actions that can be taken by governments to reform the health system under three reform goals, which respond to the immediate, emerging and systemic priorities:

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

- Under this reform goal the Commission focuses on five priority areas:
    a) Universal basic dental health services
    b) Timely access to quality care in public hospitals
    c) Crisis mental health services
    d) Closing the gap for Aboriginal and Torres Strait Islander health
    e) Delivering better outcomes for people in remote and rural areas

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

This reform goal is based on three design elements for the health system:
    a) To embed prevention and early intervention into every aspect of our health system and our lives
    b) Connecting and integrating health and aged care services for people over their lives
    c) Evolving Medicare- beyond a Medicare Benefits Schedule

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

- Recommendations in this area are grouped under five levers of reform to support a system adaptive and responsive to changing needs:

    a) Strengthened consumer engagement and voice
    b) A modern, learning and supported health workforce
    c) Smart use of data, information and communication
    d) Well-designed funding and strategic purchasing models
    e) Knowledge-led continuous improvement, innovation and research.

PM&C's preliminary analysis of the key recommendations

The interim report contained 116 reform directions and as a result of feedback some of these proposals have been refined, some have remained and there are some additional proposals. The final report contains 123 recommendations. s 47C [redacted] We have grouped the major recommendations which respond to the immediate, emerging and systemic problems and challenges in the health system, as identified by the Commission, under the following areas:

s 47C [redacted]

s 47C [redacted]

Reforming Governance

The interim report put forward three reform options for governance and as a result of consultation these have been refined and the Commission now proposes two main recommendations:

- A Healthy Australia Accord; and
- Medicare Select

A Healthy Australia Accord

The Healthy Australia Accord retains a governance model of shared responsibility for health care between the Commonwealth and state governments, but with significantly re-aligned roles and responsibilities. Under this model the Commonwealth would take full responsibility for the policy and public funding of primary health care, basic dental care and aged care. The Commonwealth would also be responsible for purchasing health services for Aboriginal and Torres Strait Islander people under a National Authority (discussed below).

Under the Accord the states and territories would remain responsible for public hospitals, and Commonwealth funding would be allocated in the following way:

- 100 per cent of the efficient costs of public hospital outpatient services using an agreed casemix classification and an agreed, capped activity-based budget
- 40 per cent of the cost of care for every episode of acute care and sub-acute care for public inpatients and emergency department treatment.

The Commission proposes that over time the Commonwealth would build capacity and experience in purchasing public hospital services and could increase its funding to 100 per cent of the efficient cost for these services.

s 47C

The Commission notes that the Commonwealth could move to 100 per cent of the efficient cost of care in hospitals, which would give it the capacity to set funding levels across the health care continuum. According to the Commission the Commonwealth could pay a hospital or health care benefit directly to a public hospital which may lead the states to

corporatise their hospitals and establish independent boards and management. The Commission has not put forward particular recommendations in this regard and even envisages that states and territories may remain responsible for operating public hospitals. However, with the Commonwealth having almost full funding responsibility and reducing GST revenue in recognition of this fact, it is unlikely that states would continue to have a role, leaving direct funding to hospitals open as an option with efficiencies gained being re-invested into hospital services.

This move towards a single funder for health care services would allow more radical changes to the system and the Commission proposes a social insurance model called 'Medicare Select'.

Medicare Select

The Commission recommends that the Government consider Medicare Select as a long term funding option. Under Medicare Select, it is proposed that the Commonwealth becomes the sole government funder of health services. Some of the features of this model are:

- The Commonwealth would be the sole funder of health services, with funding flowing from consolidated revenue or a dedicated levy.
- The Commonwealth would determine the universal service entitlement and service obligation for all Australians.
- All Australians would automatically belong to a government operated health and hospitals plan but could choose to move to another plan.
- Plans would cover a mandatory set of health services, made explicit in a universal service obligation which would include hospital and medical care and pharmaceuticals.
- People could purchase from private health insurers additional coverage not included under the universal service obligation.
- The Commonwealth would distribute funds to plans on a risk-adjusted basis for each person – reflecting the likely health needs of the person.
- Through contracting arrangements with providers, plans would purchase the services to meet the full health care needs of their members.

The Commission recognises that this is a radical proposition which requires significant further consideration and recommends that the Commonwealth commits to exploring the model and a detailed list of issues over the next two years.

s 47C

The Commission argues that the providers of plans would be motivated to invest in wellness and prevention to limit their members exposure to the health costs, however, this motivation would only exist if members are loyal to their plans. This has to be balanced against competition, which will only work if consumers can change plans easily. s 47C

The Commission also envisages that there would be co-payments for mandatory coverage, and although these would be limited by regulation, this would be a fundamental change to universal, free hospital care.

s 47C

Hospitals

As outlined above the Commission proposes activity based funding arrangements for public hospitals. These recommendations go beyond what has already been agreed through COAG to implementation of activity based funding at a much faster pace, as early as 2011. The Commission's view is that existing classification systems should be utilised rather than agreeing classification and costing models with the states and territories. Apart from activity based funding the Commission also proposes that emergency departments be funded through a combination of fixed grants and activity based funding and that activity based funding include the cost of capital.

The Commission also recommends National Access Targets be developed and adopted to assess the timeliness of care across all health services, including public hospital services

s 47C

Primary Health Care

The NHHRC proposes a range of reforms which aim to deliver an integrated 'person-centred' primary health care system. Driving its agenda is a Commonwealth takeover of policy and public funding responsibility for primary health care. Under the takeover, the Commonwealth would assume new funding (but not service delivery) responsibilities for currently state, territory and local government-funded community health services, family and child health services, community nursing, allied health and alcohol and drug treatment services. These responsibilities would be in addition to a Commonwealth funding takeover of emergency departments, which would include primary care type patients.

Other recommendations flagged in the NHHRC's Interim Report and refined for the Final Report, include new Comprehensive Primary Care Centres and Services; voluntary enrolment for people with chronic disease, long-term mental health problems, people with disabilities, young families and Indigenous people; and new Primary Health Care Organisations (replacing the Divisions of General Practice) to support service coordination and population health planning. The final report also recommends evolving Medicare from a mainly fee-for-service payment system to a broader mix of payment arrangements including, payments for a course of care, grants, outcome payments and salary.

Alignment with draft National Primary Health Care Strategy

On 30 June, the draft care strategy, "Building a 21st Century Primary Health Care System" ('the draft Strategy') was delivered to the Minister for Health and Ageing. The draft Strategy is a made up of 5 key "building blocks" and 4 priority directions for change. It is not a detailed implementation plan but provides a "road map" for future reform of primary care.

The NHHRC's proposed reforms broadly align with some of the major reform directions for primary care under the draft Strategy. Key areas of agreement include:

- Infrastructure to support new models of care, including Comprehensive Primary Care Centres;
- Voluntary enrolment to better support chronic disease management; and
- New networks, partnerships and governance arrangements to support integration, which could be implemented through regional governance structures such as the NHHRC's proposed Primary Health Care Organisations.

Draft Primary Care Strategy and the NHHRC's governance takeover

s 47C

. The Commission's proposal for primary care is centered around the Commonwealth becoming the sole funder. It is their view that current service fragmentation (between GPs, community health and other community-based care sectors) and the lack of multidisciplinary care will remain unresolved while responsibility for policy and funding is split between three levels of government. In contrast, the Strategy does not consider a takeover is a necessary precondition to achieving more integrated care. However, both the Strategy and the Final Report note that a fresh look at funding approaches for primary care, both within the MBS and other models (such as performance, outcomes, capitation, salary and program funded), will be required in order to deliver true integration across community-based care.

Smart use of data and information – the e-Health agenda

The draft Strategy and the NHHRC agree on the need for information and new technologies to support e-Health, patient centred care and self-management. The Commission emphasises the importance of person-controlled electronic health records as a means of promoting continuity of care and improving health outcomes. The Commission also calls on governments to expedite the e-Health agenda. Irrespective of decisions on governance, these are priority reforms that need to be pursued and where substantial work has already been undertaken by governments.

s 47C

Commission recommends that in the first instance, under the Healthy Australia Accord, the states and territories agree to transfer primary care funding to the Commonwealth (approximately $4 billion/annum) for a three year transition period. Over this time, the Commonwealth would gain an understanding of the state-run services so that it could fully takeover responsibilities. s 47C

A Commonwealth takeover of primary health care funding and policy would represent major reform and the implications both in terms of service delivery and financial risk need to be carefully considered. The Commission recognises that primary health care services operate differently across jurisdictions and the Commonwealth needs to consider what service models it wants to encourage and fund. The Commission does not advocate that the Commonwealth take responsibility for delivering services, nor has it clearly framed a distinction between community-based social support services and clinical services. s 47C

This is particularly relevant in areas of mental health, drug and alcohol and child and maternal services.

s 47C

Dental

Denticare: universal access to dental services funded through an increased Medicare levy

The Commission proposes a 'Denticare Australia' scheme providing universal access to preventive and restorative dental care, and dentures, for all Australians. Denticare would operate under a social insurance model similar to the proposal for Medicare Select. People would be able to choose between public and private dental health plans, with the Government meeting the full cost of services under the public plan and 85% of costs under private plans. Additional recommendations include a dental residency program ($200 million), dental school expansion ($100 million), revitalised school dental programs ($100 million) and increased oral health promotion ($20 million).

The Commission proposes an increase in the Medicare Levy by an additional 0.75% of taxable income to fund Denticare and associated measures (approximately $5.5 billion per year).

s 47C

Mental Health

Better Care for people with serious mental illness

The Commission makes a series of recommendations to facilitate better care for people with serious mental illness including: the expansion of sub-acute services in the community; access to stable accommodation and other social supports; and ensuring that all acute mental health services have a 'rapid response outreach team' available 24 hours a day. The aim is to provide intensive community treatment and support as an alternative to hospital based treatment. Multi-disciplinary community based sub-acute services provide what is known as step up and step down care. That is, they help manage the care of people with

serious mental illness living in the community before they become acutely unwell (step up), and provide an alternative to support recovery and better functioning after an acute hospital admission (step down). This links closely with the provision of stable accommodation and other social supports – people who exit sub-acute care remain vulnerable and without ongoing support are susceptible to a downward spiral which could result in acute admission, or worse. The purpose of rapid response assessment teams available 24 hours a day is to urgently assess a person experiencing a mental health crisis and provide any required short term treatment.

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s 47C The Commission has identified annual costs in the order of $270 million, excluding the provision of stable accommodation, which is a state responsibility.

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Encouraging good mental health in our young people

The Commission recommends that a youth friendly, community based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. This recommendation seems to be an extension of the type of services already rolled out through *headspace,* Australia's National Youth Mental Health Foundation. These services would include face-to-face, telephone and internet based approaches and would be set up to refer people to appropriate primary care or specialist services where required. The Commission argues that most new cases of what ultimately become chronic mental illness, emerge in late adolescence and the early adult years. The Commission reports that among young people aged 16-24 years, more than 25% reported experiencing at least one mental health disorder in the previous 12 months and that one in ten young people will have both a mental health disorder and a substance use problem. Further, young people may avoid seeking help for their illness because health services are not set up in a youth friendly way.

The Commission further recommends a national rollout of the Early Psychosis Prevention and Intervention Centre model, involving case managers and clinical experts working with a young person to help them adjust to their diagnosis, receive early treatment and continue living at home. The Commission reports that this should result in fewer unplanned hospital visits and help to improve functioning and social outcomes for affected young people.

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s 47C In particular, we note that in relation to the youth friendly community based services, thirty similar services have already been rolled out through *headspace*, and the government has recently committed an additional $35.6 million to this organisation. The Commission estimates the annual cost of an expanded headspace program at $30 million, plus $30 million capital. An independent evaluation of *headspace* is currently underway and due to report in October 2009. s 47C

In relation to a National rollout of the Early Psychosis Prevention and Intervention Centre model, s 47C

Prevention

The Commission makes a number of recommendations about embedding prevention and early intervention into the health system. These recommendations include: establishing an Australian Health Promotion and Prevention Agency; developing 'Healthy Australia Goals 2020', where Australians contribute to setting priorities about the improvements they want to achieve in health; shifting the curve of health expenditure toward prevention including establishing a common national approach to the evaluation of all health interventions; building prevention and early intervention into the health system; a healthy start to life for all Australian children; and encouraging good mental health in our young people. Separately to these preventative health specific recommendations, the Commission also recommends several measures that can be linked to preventative health including building health literacy, fostering community participation and using information to promote better health outcomes and healthy communities. The aim of the recommendations proposed by the Commission for preventive health is to encourage and support everyone to achieve their maximum health potential, regardless of their age, or whether they have a chronic illness or a disability.

s 47C In particular the Preventative Health Taskforce has now provided government with its National Preventative Health Strategy and implementation has only just commenced on the Preventive Health National Partnership (NP) that was agreed by COAG on 29 November 2008. It is worth noting that in general the Commission's recommendations are reflected in the Strategy and the government has already taken steps to establish a Preventive Health Agency under the Preventive Health NP.

The Commission has identified additional annual costs of between $378 million - $978 million, noting funding already allocated through COAG.

<u>Key issues relating to the National Preventative Health Strategy</u>
The National Preventative Health Strategy provides a broad framework for preventative health through its recommendations on establishment of the National Prevention Agency, infrastructure development and workforce redesign, and builds on the outputs and outcomes of the Preventive Health National Partnership. In addition to the broad framework, it also outlines three separate strategies and implementation plans for national reform in the key areas of obesity and alcohol and tobacco use. The Taskforce notes that its implementation plan outlines three phases 1) set in place urgent priority actions, 2) build on these actions,

learning from new research, program implementation and national trials and 3) ensure long-term and sustained action, based on learning from the previous phases.

The Strategy recommendations on alcohol use are largely regulatory, proposing self-regulation on advertising, promotion and sponsorship, and moving to imposed regulatory reforms if self-regulation proves unsuccessful. For obesity, the Strategy approach is consistent with the targets for obesity in the Preventive Health National Partnership, with the focus more on raising awareness and encouraging a cultural shift towards an active lifestyle and good nutrition. For tobacco the focus is on significantly increasing taxation and ending all remaining forms of tobacco advertising and promotion. All three key areas are underpinned by: social marketing; the aim to involve families, workplaces and communities as far as possible; incentivising and rewarding good performance; and building and monitoring an evidence base.

The Taskforce has developed a broad ranging strategy, combining marketing, education, taxation and regulation. While the Strategy represents a comprehensive approach and is likely to be applauded by many health advocates, extensive consultation is required across a range of industries to determine impacts and views. It is likely that many aspects of the strategy will meet resistance. For example, recommendations to ban junk food advertising is an ongoing contentious issue with impacts on advertisers and broadcasters. Recommendations to phase out alcohol advertising during sporting broadcasts impacts on the broadcaster, advertiser and the sport itself. We also note that in all three priority areas – obesity, smoking and alcohol – the Taskforce proposes taxation as a lever to facilitate behavioural change. This is a matter in scope of the Henry Review, the outcomes of which should also inform the Government's response to the Strategy.

Aged Care

The Commission proposes sweeping reforms to aged care funding and program design that are intended to increase competition and efficiency between providers, increase client choice and improve the responsiveness of the system.

The most significant reform would involve funding people instead of places, by ending the annual process of allocating new places to providers based on the number of people over the age of 70 in each aged care planning region. Funding would instead attach directly to people who are approved to access subsidised care by Aged Care Assessment Teams, possibly through a voucher system. s 47C

The Commission also recommends relaxing controls on the fees providers are able to levy from clients, including allowing accommodation bonds for high level residential care once deregulation has sufficiently increased competition in supply and price. Bonds are currently only permitted for low level care and a limited number of 'extra services' (ie premium accommodation) places. Consolidating the range of aged care programs under the Commonwealth is suggested to allow a more streamlined and responsive system with consistent eligibility criteria across all aged care programs. This would include sole Commonwealth responsibility for the aged care component of the Home and Community Care (HACC) program.

Additional recommendations aim at better access to standardised safety and quality information, improved primary health and geriatric care provision residential facilities, and more flexible funding arrangements and client choice in community care. A five-year implementation plan for aged care reform would be developed jointly by the Commonwealth

and stakeholders. The Commission estimates the cost of its aged care reform proposals in the range of $530 - $838 million per year.

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The majority of the Commission's aged care reform proposals were included in the interim report and generally well received by stakeholders. The Productivity Commission echoed many of the Commission's views on the need to increase competition to improve efficiency and service-quality in its *Trends in Aged Care Services* and the *Annual Review of Regulatory Burdens*. However, the Aged Care Association of Australia, one of the major industry peaks for both for-profit and not-for-profit providers, expressed concern about proposals to increase competition between providers.

Aboriginal and Torres Strait Islander Health

The Commission has made a number of recommendations regarding Indigenous Health. There is an extensive Closing the Gap agenda already underway through COAG, totalling $4.6 billion across health, early childhood, housing, employment and remote service delivery. Improving Indigenous health is a high priority. With the exception of a National Aboriginal and Torres Strait Islander Health Authority, which s 47C

A national Aboriginal and Torres Strait Islander Health Authority to purchase services under an Indigenous-specific schedule

Under this reform, the Commission proposes the establishment of a National Aboriginal and Torres Strait Islander Health Authority to purchase services specifically for Indigenous Australians and their families as a mechanism for 'closing the gap'. The Authority would operate in much the same way as the Repatriation Commission/Department of Veterans' Affairs does for the veteran community, with services purchased on a fee for service basis through mainstream health providers and Aboriginal health organisations. Indigenous people would need to register to receive services funded through the Authority. Registration would be voluntary, and those not registered would still be covered by existing Medicare arrangements.

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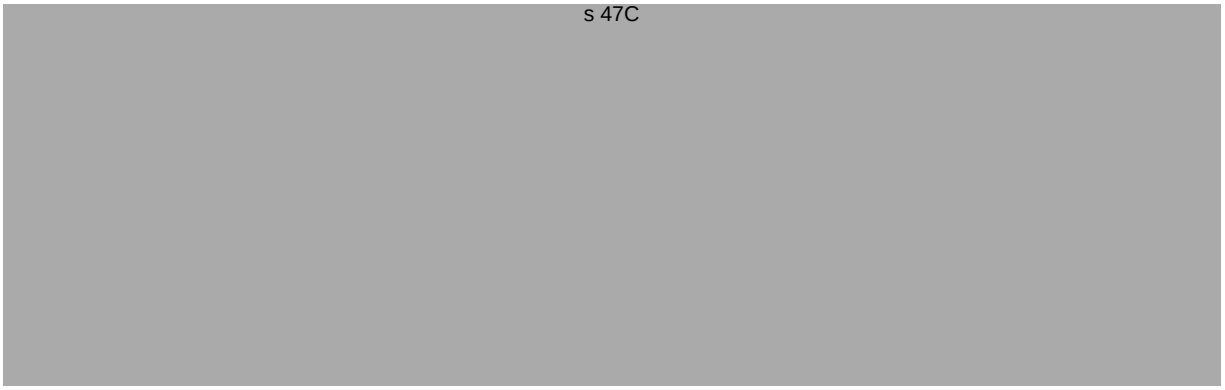

The Commonwealth investment in the Indigenous Health NP is focused on making the current structures work for Indigenous people – strengthening accredited Aboriginal community controlled health services to continue to provide culturally appropriate comprehensive primary health care and supplementing this with improved capacity for mainstream services to meet the needs of Indigenous Australians in urban and regional areas.

The NP will use a range of strategies to enable Indigenous Australians to access primary health care, particularly through Indigenous Outreach Workers, who will also assist individuals through the primary health care system. Funds will be available for specific geographical areas so that they can purchase additional services that meet the needs of the local population and which complement and enhance the current services that are available in the area. The amount of funding available to an area will be determined by the number of Indigenous Australians living in the region, adjusted to reflect the number of people actually participating in the Chronic Disease Management Program.

Improving nutrition in targeted remote Indigenous Communities

This reform stresses the importance of good nutrition and a healthy diet as key elements of a healthy start to life, and recommends an integrated package to improve the affordability of fresh food – particularly fruit and vegetables – in targeted remote communities. This strategy includes subsidised foods, nutritional education programs and vitamin and nutrient supplements for infants, school children and pregnant women.

Comment: At the 2 July COAG the Working Group on Indigenous Affairs, led by Minister Macklin, was tasked with investigating the issue of food security in remote communities. This is in recognition of the role that good food and nutrition have in Closing the Gap in life expectancy. The Working Group will look at both supply and consumption issues, and will draw on the experience of the NTER store licensing, which has had substantial benefits in

improving food security. Community members have access to a wider range of nutritious food, and families are taking up the option to purchase this food and take responsibility for their own health.

The Working Group is to report back to COAG by the end of this year.

Train an Indigenous Health Workforce

This initiative promotes the importance of an Indigenous health workforce, as well as the provision of culturally appropriate care and services.

Comment: The provision of improved cultural security in services and increased cultural competence of the primary health care workforce is an outcome in the National Partnership Agreement on Closing the Gap in Health Outcomes.

This NP aims to increase participation by Indigenous Australians in decisions about their own health care. In particular, Commonwealth funding will be provided to fund local Indigenous people to work as Indigenous Outreach Workers in Indigenous health organisations to assist Indigenous people to access health care services.

The Commonwealth's investment of $805.5 million over four years through the NP on Closing the Gap in Indigenous Health Outcomes will also provide a substantial new funding stream through Medicare and Practice Incentive Payments for accredited Aboriginal community controlled health services to continue to provide culturally appropriate comprehensive primary health care for Aboriginal and Torres Strait Islander peoples with chronic disease.

Costs

The NHHRC has estimated the cost of health reform to be between $2.8 billion and $5.7 billion. These costs are a full year cost, once the reform agenda has been implemented and has commenced. We understand that the NHHRC considers that these costs would not be achieved for five years, with smaller costs in the preceding years. These costs include all of the major reforms, but are indicative only and do not include the costs of smaller initiatives worth less than $100 million. In addition, in order to drive the reform agenda the NHHRC is proposing transformative capital of between $4.3 billion and $7.3 billion over five years be provided. This would include funding for comprehensive primary care centres, enhanced sub-acute services, funding for hospitals reshaping (including funding for elective surgery units and improving emergency department efficiency), expanded dental services and for e-health.

This funding includes efficiencies (of between $570 million and $1.3 billion) gained from the introduction of activity-based funding, where the Commonwealth provides funding based on an efficient price. s 47C The NHHRC (based on AIHW projections) estimate that over the longer term, expenditure on health and ageing would be reduced by 0.2 per cent of GDP by 2032-33 (or $4 billion a year). In addition, significantly more services would be delivered, including between 1 and 1.3 million additional bed days (or freeing up 2,900 hospital beds) and allowing an additional 160,000 plus episodes of acute care which require an overnight stay to be delivered.

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