



## FIT FOR THE JOB

ADAPTING TO  
AUSTRALIA'S NEW  
HEALTHCARE  
CHALLENGES

BUSINESS COUNCIL OF AUSTRALIA



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## EXECUTIVE SUMMARY

The BCA's vision is for Australia to be the best place in the world in which to live, learn, work and do business. Integral to this vision is a healthy population and a world-class health system. While it has functioned successfully to date, Australia's health system now faces major challenges of adaptation to new and emerging needs. Without systemic change, the financial and operating pressures evident in the existing system are likely to grow, and trend increases in ill health and the ageing of the population are likely to continue. The result will be that our national health status will decline and our social and economic prosperity will suffer.

Improving the health of Australians is an important element in building for future prosperity and sharing it more evenly among Australians. Health reform is an important and urgent part of the ongoing reform agenda.

The aims of health reform are twofold:

- To improve the health of all Australians to underpin future social and economic prosperity.
- To improve the effectiveness and efficiency with which our healthcare system operates.

From an economic perspective, the first aim – improving Australians' health – is essential to increasing workforce participation and productivity.

From a social perspective, improved health is essential to improve the capacity of all citizens to fully participate socially and economically.

The second aim – improved effectiveness and efficiency – is also important economically. The healthcare sector accounts for 10 per cent of GDP, and is growing fast. The efficiency with which the sector utilises the economy's resources has a large impact on the Australian economy. The effectiveness with which it operates directly affects the health of Australians. Inadequate quality controls are costing lives and inflicting serious injury for too many.

The health services we need are based primarily on the pattern of diseases, current and projected, on the determinants of that pattern of diseases, and on the best-known ways of preventing, containing and/or treating those diseases. The services we receive are affected by decisions about what will be provided, to whom and at what quality and cost. The chronic, or ongoing, diseases dominating Australia's disease pattern, such as cancer, heart disease, diabetes and dementia, are different from the pattern of infection, injury and episodic illness that occurred previously. We have not yet put in place the prevention and care models appropriate to chronic disease. That is exacerbating the pressures on the current system as it copes with rising demand and an ageing population.

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To deal with these rising burdens, Australia needs a new comprehensive national health strategy. That strategy needs to not only address the requirements that are known, but also establish mechanisms that will capture the future needs arising from developments such as climate change and the greater movement of people internationally, together with new cost-effective treatments and prevention methods. The National Health and Hospitals Reform Commission (NHHRC) in its interim report on the health system identified many of the reform directions that health professionals agree are needed, but which they are collectively unable to implement.

In our view, to drive this strategy, we must overhaul the health system's current governance, funding, information and quality systems. To overcome the current lack of a single accountability in health policy and provision, Australia must establish one independent body that can lead and be held accountable by the Australian community. Its primary functions will be to reconfigure the nature of health services to meet the pattern of demand, address the multiple determinants of health and to ensure that the system is innovative, efficient and above all, delivering high-quality outcomes. A key principle to drive this new system will be 'patient-centricity': the redesign of all key processes around patients, rather than specific procedures, body parts or episodes, and the integration of preventative with curative health and of physical with mental health. The main levers of change lie in the development of revised funding and incentive systems, the implementation of new patient-based information systems and e-health records, and the mandating of quality assurance systems.

We therefore call for:

- A new comprehensive health strategy.
- An independent health body to lead and drive that strategy.
- Revised funding arrangements.
- Establishment of national, patient-based information systems.
- Establishment of a new national quality assurance system.
- Creation of a national health workforce strategy.
- Change to be undertaken in accordance with best practice.

The current healthcare system is complex, made up of myriad interlocking but often disconnected operating systems. It is not fit for the job. Changing it will require an intricate process of adaptation.

The opportunities for unintended consequences are high. For this reason we have proposed a staged approach to change so that adjustments can readily be made along the way. The challenge is to reshape the system to promote health and accommodate new patterns of ill health and ensure the system's financial sustainability, while at the same time continuing to maintain and improve existing services.

We must tackle this task with great urgency. The current healthcare system is fragile and beset by clear pressures and systemic failures. It is often maintained only through the commitment of those at the front line.

First and foremost, the adaptation must be guided by a shared vision of what Australia needs and why we need it, with an inclusive leadership driving the implementation of that vision. This is not a bureaucratic exercise, and it demands highly professional clinical leadership. But it is a change process that involves all of us and the debate must be widened beyond the health sector alone.

Health is everybody's business.

## INTRODUCTION

The Business Council of Australia's vision is for Australia to become the best place in the world in which to live, learn, work and do business. Integral to this vision is a healthy population with an effective healthcare system. Australia has enjoyed an enormous increase in prosperity in the past 20 years, and improved health outcomes have been both a consequence of that prosperity and a key economic driver of it. This is now in jeopardy. Like all other developed countries, Australia faces significant challenges in maintaining high standards of living in the face of increased international competition, major economic restructuring as energy costs increase, and large demographic changes that affect the capacity to generate future productivity increases and economic growth. A continued economic reform agenda is essential to address these challenges, even as Australia responds to short-term economic pressures.

Improved health is an investment in future prosperity in the same way that school education, industrial research and roads are investments in the future. Without improved health, we cannot lift participation in the workforce by many underrepresented groups or optimise productivity. Improving health entails promoting physical and mental health and wellbeing by first addressing the causes of the current pattern of disease and then treating that pattern cost-effectively.

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In particular, the prevalence of preventable chronic disease among Australians potentially offers significant opportunities for both effecting the improvement in health outcomes we seek and at the same time containing the demand for greater resources in the health sector. Further reforms within the health, community and aged care sectors can also improve the quality of, and efficiency with which, health and related care services are provided.

Building on our paper *Health Is Everybody's Business* (October 2008), this paper contributes to the current federal government health review processes by setting out our understanding of what must be done to ensure that the health system continues to deliver high-quality health care and a refined health management system that promotes the health of all Australians. It begins by restating our understanding of the challenges facing the sector, including the economic significance of those challenges, and then outlines what we need in a health system, the constraints to our moving to it, and the actions we need to take to overcome those constraints. In putting forward these solutions, we draw on international experience, the experience of other sectors in dealing with similar challenges of transformation, and the experience of our members in working on change within the sector.<sup>1</sup> We also respond to the reform directions proposed by the National Health and Hospitals Reform Commission.

## PART 1: BACKGROUND

### OUR UNDERSTANDING OF THE ISSUES

#### 1.1 Health is a significant economic issue

Health is of deep economic as well as social significance, affecting both the productive capacity of the workforce and the allocation of resources in the economy.

##### 1.1.1 The health of the population and workforce directly affects the size and productivity of the workforce

Health costs to the economy, direct and indirect, are driven by the pattern of disease<sup>2</sup> and the methods by which those diseases are treated. That pattern is, in turn, influenced by environmental, social, socioeconomic, genetic, and behavioural factors. Improving health means tackling the factors affecting health as well as ensuring the application of effective treatment for diseases when they occur.<sup>3</sup>

Over the past 30 years, broadly based prevention and public health strategies, together with increasingly sophisticated diagnostic and treatment patterns, have strongly contributed to our longer life expectancies and reduced rates of premature death and injury.

But, the pattern of disease and its determinants in the 21st century are different from their antecedents, and require new strategies. Key features include the prevalence of chronic disease<sup>4</sup> and the contributory lifestyle behaviours:<sup>5</sup>

- Seventy-five per cent of all deaths of individuals under the age of 75 years are preventable.
- In 1996, chronic diseases were estimated to account for 80 per cent of Australia's total disease burden: the top 12 (which contribute 42 per cent), cancer (19 per cent), cardiovascular and coronary disease (17 per cent), and mental illness, which is the third-biggest contributor (13 per cent).
- Seventy-seven per cent of all Australians have at least one long-term condition, with many adults at risk of developing chronic disease.
- Behavioural factors, together with associated risk conditions, are estimated to contribute 30 per cent of the overall disease burden; for example, 54 per cent of adults are obese or overweight.

The financial and economic impact of chronic disease is significant:

- The economic cost associated with chronic disease is estimated at 3 per cent of GDP, or \$30 billion.<sup>6</sup>
- In 2000–1, 70 per cent of the total health expenditure related to chronic disease.
- In 2003–4, 12 chronic diseases accounted for 21.6 per cent of all hospital admissions with an average stay of seven days.<sup>7</sup>
- In 2005–6 about 400,000 potentially preventable hospitalisations, or 5 per cent of the total, related to chronic diseases.<sup>8</sup>

The National Preventative Health Taskforce has estimated that:

- Smoking-related illness costs up to \$5.7 billion per annum in lost productivity.
- Twenty per cent of Australians drink at risky levels, resulting in additional direct health costs, accidents and violence, policing costs and productivity losses of \$10.7 billion.<sup>9</sup>

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Chronic disease, in conjunction with the ageing of the population, exacerbates the challenge of maintaining workforce participation and productivity. Ageing alone means that Australia's workforce participation rate is set to decline, leading to a projected 0.3 per cent reduction in GDP.<sup>10</sup> That decline is hastened by ill health; only 30 per cent of those in poor health participate in the labour market, compared to 80 to 90 per cent with good health.<sup>11</sup> Conversely, continued workforce participation can contribute to better health for older workers.<sup>12</sup> Ill health also affects the productivity of those in the workforce. Estimates have put the cost of absenteeism and presenteeism<sup>13</sup> at \$7.0 billion per annum and \$25.7 billion per annum respectively.<sup>14</sup>

#### *1.1.2 The health of the population is a key driver of health costs*

The rate of growth in health costs, together with the expected growth in age-related payments, are expected to put extreme pressure on government budgets.<sup>15</sup> Some state governments<sup>16</sup> predict that if health expenditures continue to rise at current rates they will consume 100 per cent of their budgets by 2033. The linked growth of obesity and Type 2 diabetes will cause annual health costs to increase from \$1.4 billion to \$7 billion by 2032.<sup>17</sup> Although health expenditures increase as per capita income increases, the projected increases in government outlays at both state and federal levels suggest that health will take ever-increasing proportions of total outlays, potentially crowding out desired expenditures in other sectors. While this may be consistent with overall population preferences and represent a good return on investment,<sup>18</sup> the indirect relationship between demand and pricing means that this conclusion cannot be drawn in the Australian context.

#### *1.1.3 The health and wellness sectors are large and growing sectors of the economy*

The health sector alone accounted for nearly 10 per cent of Australia's GDP in 2005–6 (increasing to 20 per cent by 2047<sup>19</sup>) and 7 per cent of the civilian workforce. Although the size of the wellness sector (incorporating, for example, healthy foods, fitness facilities, spas, complementary medicines and alternative therapies) is not well documented, it is understood that expenditure on complementary medicine is approximately \$3 billion per annum and that approximately 8 per cent of the population use health and fitness facilities.

In summary, health is an economic as well as a social issue, affecting the rate of workforce participation and productivity and the level of healthcare costs and commitment of government budgets.

Policies that improve health and therefore workforce participation and productivity, and those directed to improving the efficiency and effectiveness of government health expenditure, are critical elements of Australia's economic reform agenda.

#### *1.2 The challenges facing the health sector*

In *Health Is Everybody's Business*, the BCA reviewed the current state of Australia's health and the generally accepted challenges that confront its health system. That review concluded that a health system had evolved in Australia that had delivered significant improvements in health outcomes for Australians generally. However, it also concluded that those benefits are not spread evenly despite the aim of universality, and that the clinical and financial sustainability of the system is in question as costs rise and the pattern of disease changes.

The issues identified in the *Health Is Everybody's Business* paper were:

- Uneven distribution of service provision, which means health outcomes depend on location or income level.
- Inconsistent quality of outcomes, meaning that an unacceptable number of Australians continue to die or be injured unnecessarily.
- Rising costs and government outlays, which threaten the financial sustainability of the health system.
- A changing pattern of disease with a significant rise in chronic disease, requiring different models of care facilities and support systems but also offering opportunities for lowering the level of ill health.
- Workforce shortages, composition, distribution and morale issues.
- The lack of a clear, agreed and publicly accepted plan for change.

The supply and shape of services have not kept pace with the level, distribution and nature of demand. People are living longer, but often in ill health or suffering disability. At the same time, their expectations of health treatment have risen as incomes have risen and new technologies and services have made available treatment options and access not previously possible. As a result, health costs are increasing faster than the Consumer Price Index. Services are insufficiently focused on preventing illness or cost-effectively treating people with chronic disease, and are not evenly distributed.

The deliberate rationing of new technologies and practitioners to contain costs has been partly successful, resulting in greater numbers of people being treated while containing the relative growth in health costs to the OECD average.

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However, many consider the cost containment measures used to date have reached the limit of their utility, and that more sophisticated techniques and systemic change is required to achieve greater efficiency. Further, those cost containment measures have led to the current inequities in service provision, queues and waiting lists, and have not provided the impetus to address major quality issues in the system. The paucity of publicly available outcomes and performance data means that the overall performance of the health system can be measured only by aggregated measures such as life expectancy.

The current architecture of the health system has not been designed to deal with current patterns of disease, the need for greater coordination of care, improved outcomes or to encourage efficiencies and innovation. It reflects past patterns of disease and expenditure.

- Previous public health and many urban infrastructure programs focused on preventing the spread of infectious diseases, road safety and workplace safety initiatives aimed to reduce and/or eliminate injuries, fluoridisation and public dental programs sought to reduce the incidence and impact of oral disease, and anti-smoking programs were directed to reducing tobacco use. The pattern of disease has changed, partly because of the very success of these programs and services and partly because of variations in environmental, social, lifestyle and working patterns. New prevention programs have been developed but their implementation has been hampered by lack of resourcing and incomplete knowledge about effective intervention strategies. This reflects the multi-causality of many conditions, together with inadequate understanding about how to motivate the take-up of programs by many at-risk individuals.
- Highly sophisticated care facilities and specialist services developed for the treatment of injury and disease contributed significantly to reduced death rates and improved disease and injury recovery rates. However, these facilities are now under pressure because of the failure of the system to generate alternative care models for early detection and management of chronic diseases and more diverse residential care facilities. Evaluations of coordinated care trials clearly demonstrate that current structural and operating systems render care coordination arrangements for ongoing health and chronic disease management unwieldy, unreliable and time-consuming.<sup>20</sup> The use of acute

beds by patients requiring sub-acute care reflects the lack of alternative facilities resulting from caps on bundled services, such as aged care, and inadequate investment in rehabilitation and nursing home beds.<sup>21</sup>

Changes to capital facilities, funding schedules, information systems, quality and operating arrangements are needed to bring about a patient-centric health system that deals cost-effectively with chronic disease. Significant resources are required to retool the system and to encourage different provider and citizen/patient behaviours.

The combined challenges of changing the mix of services to reflect new patterns of disease while improving the quality and equity with which they are delivered are exacerbated by skill shortages in the health and community sectors. Not only have shortages emerged as the workforce ages and its replacement rate fails to keep pace with growing demand, but also its geographic distribution and skill composition are skewed to previous demand and reward structures. These shortages are exacerbated by the rapid advances in technologies and medical knowledge and the consequent need for continual professional development, the apparent poor morale in the public sector which is leading many to move to private practice, and the traditional roles and scope of work of various health professionals that render diversification of roles a difficult option.<sup>22,23,24</sup>

Without major and systemic change, uneven distribution of outcomes will continue to belie the ideal of universality; queues and rationing will get worse; patient safety will continue to be jeopardised; the health status of Australians will remain lower than it could be, leading to unnecessary social costs and lower productivity and workforce participation than would otherwise be the case; health costs and government outlays will continue to rise, threatening to crowd out other areas of government expenditure and investment; and productivity in the sector will continue to lag behind other sectors, leading to an inefficient allocation of resources. Pressures on clinical and nursing staff will continue to mean high turnover of health staff, exacerbating the projected staffing shortages.

It is not just a matter of reconfiguring a system to meet current and expected needs arising from known demographic trends. The system needs to be able to continue to adapt to meet new needs as they arise or are anticipated.

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For example, the effects of climate change on population health can be expected to accelerate. Changes in weather patterns, changes in water storage arising from drought, a more mobile population, faster transport and the growth in international tourism are raising the prospect of the re-emergence of infectious diseases (new and historical) as a source of ill health, even death. Similarly, changing biosecurity risks are an emerging and largely unpublicised threat to the health system. The early warnings provided by bird flu and equine influenza show the systemic failures and lack of connection between quarantine and health systems.<sup>25</sup>

Health policymakers and Australian governments generally understand and accept both the economic and social importance of improving health outcomes and the efficacy of health care, and there is general agreement about what needs to happen, but change is slow, incremental and largely uncoordinated.<sup>26</sup> Key stakeholders within the system, including the public, have been left in the dark about the sources of system pressures and the plan to alleviate those pressures. The current review process of the National Health and Hospitals Reform Commission represents a significant opportunity to break the impasse by providing a blueprint for a comprehensive national health strategy that addresses Australia's current and projected health and disease pattern.

In summary, the issues affecting the current Australian healthcare system have been developing for a long time and are well known to policymakers and representatives within the sector. However, despite this, changes to the system have been uncoordinated, incremental and slow. Without major and systemic change, the current failures and pressures within the system will worsen and will represent a major drain on Australia's future economic and social prosperity. The current NHHRC process must deliver a blueprint for a comprehensive national health strategy adapted for the 21st century.

## PART 2: WHAT DO WE NEED?

### A COMPREHENSIVE, FUTURE-BASED NATIONAL HEALTH STRATEGY

The health services we need are based primarily on the pattern of disease, current and projected, its determinants and the best known ways of preventing, containing and/or treating those diseases. The services we receive are affected by decisions about what will be provided (the principles of support), at what cost and what quality. The current health system and associated aged care system evolved in response to past patterns of disease and population profiles. As these change, we need a new set of strategies.

Moreover, change must be built in. It is not enough to address what is known or expected. That strategy must build in the capacity for future scanning, both in terms of potential demands arising from phenomena such as climate change and greater international people movements, and the potential of new knowledge and technological advances to open up new avenues for prevention and treatment. This suggests a strong case for both ongoing evaluative research and new medical and clinical research.

#### ***2.1 The current and projected pattern of disease, and the best known ways of preventing, containing and/or treating that pattern of disease***

##### ***2.1.1 Prevention***

Because optimisation of health is a fundamental aim and principle underpinning any national health strategy, and because of the incidence and impact of preventable illnesses and injuries, prevention is necessarily a critical element of a comprehensive health strategy. Prevention, in turn, requires us to address the determinants of health: social (education, workplace, individual lifestyle), economic, environmental and biomedical determinants.

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Typically, this will require coordinated input from across policy agencies (including transport, education, emergency services, planning, environmental services, workplace safety, community services, agricultural and economic development agencies) and across jurisdictions, including local government. Development of preventative health initiatives then requires a whole-of-government approach. By implication, the comprehensive health strategy becomes a whole-of-government strategy.

Preventative and public health programs are not new. They have successfully reduced past sources of early death and preventable diseases. Today our pattern of disease is dominated by largely preventable disease or injury and we know that lifestyle behaviours contribute some 30 per cent of the disease burden. This strongly implies a need for renewed focus on prevention. However, in promoting this cause, we recognise that current knowledge about which interventions are effective to prevent the onset of many chronic diseases is still developing, even where risk factors and their relationship to disease are well understood. This means that the health strategy needs to incorporate targets and initiatives on what is known and to increase the level of research, development and evaluation into that which is not known. Current focus on programs, such as workplace health and safety, immunisation and road trauma, must continue strongly as we develop greater understanding of how to address and reduce the incidence of risky lifestyle behaviours. The balance between general education campaigns, targeted initiatives for at-risk groups, restructured access to 'bad' products and more prevention-focused primary care arrangements is still to be developed and evaluated. The NHHRC is right to warn that preventative health programs, while a major area for development, are not a panacea and that considerable work on developing appropriate mixes of policy will be necessary.

#### *2.1.2 Early detection and ongoing coordinated care*

Research shows early detection and ongoing management of symptoms can reduce the disease burden. The models of care appropriate to those processes are different from those which have gone before, and they offer more cost-effective means of managing disease. They depend heavily on a strengthened primary care system, continued investment in early detection and screening diagnostics, ongoing management through multiple health professional inputs, and the provision of more diverse sub-acute care facilities. Patient-focused coordination is critical.

So too is the engagement and active participation in the process of management by the patients themselves.

Based on the current and projected pattern of disease, and the most appropriate care models for management of that pattern, the new health strategy will reflect the need for:

- More and better linked mental health services (13 per cent of the health burden; 8 per cent of expenditures).
- More sub-acute services (to reduce the current underutilisation of acute beds), linked to acute and primary care sectors.
- Primary care services that are more combined, to support the greater workload expected in chronic disease detection, ongoing treatment and rehabilitation. This combination would result in a 'one-stop-shop' style service capacity, which would enable greater timeliness in service delivery. It would also help to reduce or remove demand for primary care that is otherwise presenting at emergency departments.
- More equitable dental health services to improve oral health, particularly in the young, elderly and geographically dispersed, thereby addressing both an inequitable situation in funding and addressing one of the contributors to chronic disease.
- Continued strengthening of early detection of coronary disease and cancer through screening and diagnostics as those services become available and cheaper.
- Continued need for – but better use of – high-quality acute and specialist services.

#### *2.2 Principles of support*

Although the health services we need are driven by the pattern of our disease and our knowledge of what are the most effective means of preventing or managing those diseases, the health services we actually provide are influenced by community preferences about the level of support to be provided, what we are prepared to pay and what quality we demand. Arising from its consultations, the NHHRC has identified a list of principles that should guide the development of a future health system. That list, while lengthy, is consistent with our understanding of community preferences. From our perspective, optimisation of health, universality, patient-centricity, value-conscious consumption and sustainability are vital.

Because of the interplay of universality, multiple sources of funding to the health sector and the consequent lack of transparency around total cost, the increasing demand for health services is not an informed preference decision.

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We believe that in redesigning the funding systems, greater transparency about price and outcomes is essential to encourage value-conscious decisions. We must stress that we are not arguing for access to services on the basis of capacity to pay, but rather, on the basis of informed decision-making. The most obvious example lies in decisions to pursue healthy lifestyles.

Citizens are entitled to expect that services are delivered as efficiently as possible. This means that operating procedures and processes are continually revised to ensure they are operating at best-practice levels and that technologies that either reduce costs or allow greater numbers to be treated will be adopted. Considerable scope exists for improvement in efficiencies, with economic benefits flowing to all stakeholders in the system, including patients.

Service quality should also be a major consideration. Again, citizens can rightly expect that they will receive services at the highest quality within the resources and knowledge available. However, to know we are getting the best health care requires a transparency and comparability of outcomes, with data that can then be benchmarked domestically and internationally.

#### **2.3 Structure of a national health strategy**

The overall health strategy needs to address the current and projected pattern of disease and its determinants in a structured way, and align services with demand in accordance with community preferences about access, cost and quality. Necessarily it will be a whole-of-government strategy and will require input across and between jurisdictions, from both public and private sectors and from individuals and employers. The overarching aim is to improve the health of Australia and to reduce the overall burden of disease. The first priority is the promotion of health and the prevention of illness and injury. The second priority is to match the right service to the right person at the right time at the right cost. We must improve quality and equity in service provision, while reconfiguring the mix of services and models of care to meet the current and projected disease pattern. Suggested objectives for a national health strategy are shown in the following table.

#### **OBJECTIVES OF A NATIONAL HEALTH STRATEGY**

1. Improve the health of Australia and reduce the overall burden of disease.
2. Improve the quality, efficiency and effectiveness of healthcare services.

By:

1. Reducing and managing the demand for health services by:
  - Promoting a healthy population and preventing ill health and injury (that is, prevention is a key plank and entails cross government/cross-policy action)
  - Promoting value-conscious consumption of health services by patients and/or their agents, using price and outcomes data.
  - Managing demand through reforming queuing mechanisms.
2. Reconfiguring the provision of services to better match health needs, and improve efficiency, by:
  - Improving quality and safety for patients.
  - Rebalancing the system to meet the current and projected health needs – facilities, transport, systems, workforce, culture/innovation.
  - Improving current efficiency and reducing patient waiting times.
  - Setting up the system for continual improvement.

#### **2.4 Implications for other sectors**

The development of a comprehensive health strategy must also trigger reviews of how services are provided in other affected sectors. For example, as noted by both the NHHRC and the Productivity Commission, the sustainability of the current aged care sector is questionable as it faces increased demand from more people and greater incidence of chronic disease. Health, nursing and accommodation services for aged care and other community-based support services are currently bundled together. At least for the purposes of planning, the demand for these services needs to be unbundled and new mechanisms for service provision explored. This necessarily affects, but goes beyond, the health strategy. Hospitals have become the residual service provider because of failures to provide the right mix of services at the right time by other community service providers and other parts of the healthcare sector.

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#### 2.5 The complexity of the challenge

We recognise that designing and implementing a national health strategy is not easy. Many different factors determine people's health. Many of these factors react with each other in a complex web of causation, a web which we do not fully understand. The sector has many professional and community stakeholders. The strategy to address the problems cannot be based on certainties, because, by definition, medical knowledge is limited – although growing exponentially – and together with technology advances, is constantly changing what is possible. All this creates a complex reform challenge.

Moreover, although the current system's pressures create a desire for change, they also restrain the capacity for change. Imposing change on an already stressed health workforce will not achieve the desired system. The way in which system change is approached, the style and timing of its implementation will be fundamental to its success. And this is not a debate or process that can be contained within the boundaries of the health sector. The implications for Australia's economic and social future prosperity are too important, the choices not purely technical. But to ensure that the whole community does indeed understand and participate in this debate, effort must be expended to engage the community. This is consistent with the demands by many within the sector for greater responsibility for health to be taken by citizens.

#### RECOMMENDATION

Develop (in an inclusive way) and publish a structured and comprehensive national health strategy designed to:

- Meet national health objectives.
- Address the current and projected disease burden (and disease determinants).
- Provide for a fit-for-purpose healthcare system that provides universal access, is affordable, and includes targeted programs for special needs groups.
- Allocate responsibilities for implementation.
- Establish targets and monitoring processes.

Invest in medical research on causes, treatment options, new technologies and effective preventative health strategies.

## PART 3: WHAT'S GETTING IN THE WAY?

It is generally agreed that the key to dealing with the issues outlined in this paper is the development of a comprehensive national health strategy that:

- Promotes health and prevents ill health by tackling the major determinants of health.
- Reshapes the healthcare system to effectively and efficiently meet the current chronic disease-dominated pattern of disease and emerging pattern arising from climate change, increased international people movements and heightened biosecurity risks.

There is also agreement about many of the features, such as strengthened primary care and early detection systems, coordination in patient care and the need for greater and more diverse accommodation and sub-acute services, together with essential building blocks, such as the personal e-health record and connected clinical and business systems.

So, if experts generally agree, what then are the structural and systemic constraints preventing faster adaptation?

Specifically, the systemic constraints include a lack of clear accountability and leadership, funding arrangements, a lack of integrated and patient-based information, and the added effects of industry structure and limited competition.

#### 3.1 Lack of clear accountability and leadership

Australia's health system has been very successful. It is highly specialised and has a strong mix of public and private provision and financing – a mix that many countries now seek to emulate. However, at a time of major change, its fragmentation, blurred Commonwealth and state responsibilities, and lack of leadership undermine its claim to be a national system and limit its capacity to adapt. The complexity and fragmentation has several implications.

- Current reforms are fragmented and incremental, rather than systemic, jeopardising the ideal of an integrated, patient-centric system.

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- Clinical and business systems are multiple and disconnected, resulting in confusion and difficulty for patients trying to navigate those systems; duplication in procedures and tests that waste patient and clinician time; longer elapsed time between diagnosis and treatment; higher than necessary administrative costs; multiple data entry input, creating more opportunity for errors and omissions; and lack of adequate monitoring of service provision.<sup>27</sup>
- Monitoring and quality systems are locally determined, reducing their effectiveness in enabling accountability, improving outcomes, changing orientations and enabling demand management.
- System developments lack coordination and integration. For example, current e-health record developments are being implemented state by state – despite a national coordinating body – and to date, have largely excluded private sector providers, despite the need to effectively tie all parts of the system together.
- Role and scope of work changes tend to be locally identified, meaning less scope for major productivity and efficiency gains are possible on a system-wide basis.
- Diffusion of successful innovations is made more difficult, relying on voluntary take-up within elements of the system.
- It is not possible to communicate to the public a vision of the need for and the nature of the changes proposed.

Fragmentation in itself is not a problem; the lack of leadership and clear accountability are the problems. Although the system is characterised by split accountabilities and a mix of public/private and NGO sector providers, under the strong leadership of a national system this diversity in providers would represent a major strength to be harnessed. With new capital and innovative staffing models required, Australia already has established mixed-sector operations that facilitate varied sources of capital for both facilities and technology and variety in 'employment' arrangements. Part of the answer is encouraging innovation and entrepreneurship to address emerging needs, including within the preventative health area. This implies the steering mechanism is clearly focused on the key metrics we are seeking to address. It does imply using the full range of policy levers, including regulation, incentives and penalties. It does not imply a large command/control, top-down bureaucracy.

### 3.2 Funding arrangements

Funding in a mixed public and private system represents a key lever for shaping and directing the health system, creating powerful incentives for both providers and individuals. Without changing those incentives and reward structures, there is little likelihood of effecting systemic change.

Current funding and financing arrangements are complex and largely reflect historical patterns of expenditure, disease and models of care. For example, the allocation of public resources between prevention and curative and ongoing care is historically based. As a result:

- 1.7% of health expenditure is on prevention and health promotion;
- 82% of health expenditure is on care and service provision (hospital, dental, medical services medicines and capital); and
- 4.5% of health expenditure is on ongoing care and follow-up through community health services.<sup>28</sup>

While the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) are key elements in ensuring the universal coverage of healthcare, their construction is highly complex and specific. They create powerful incentives because they fund particular kinds of treatment, and the MBS rewards volume and episodic care. While the PBS process for incorporation of new technologies is internationally acclaimed for its independence and focus on economic and community-rated benefit/cost, the process for incorporation of new MBS items lacks transparency. Both processes tend to be cumulative, with few items being removed or replaced to encourage the latest in best practice and/or more cost-effective treatments.

Funding arrangements reflect the nature of care models appropriate to the episodic nature of much illness or injury. However, as the pattern of disease changes, and chronic disease requires early detection, continual and coordinated care, the current system does not recognise or reward such care or patient health outcomes. Nor does it create the right incentives for avoiding re-admissions to acute care. Funding for continued care or care requiring diverse inputs is difficult to obtain and requires an administratively inefficient 'cobbling together' of multiple sources.

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Funding also tends to flow to providers (hospitals, institutions and private clinicians<sup>29</sup>) rather than to patients. Patients do not directly experience the costs of the system, even where they have private health insurance, and total costs are rarely transparent. They therefore have little immediate financial incentive to minimise costs (e.g. through prevention). Further, with a lack of outcome or performance data in the system, those 'ordering' services on behalf of patients have little capacity to discern differential value outcomes for their patients.

#### ***3.3 Lack of integrated and patient-based information***

The lack of nationally consistent and integrated information systems inhibits decision-making by governments, patients and their agents, and clinicians. Without such a system, clinical treatment is impaired, safety is jeopardised, informed policy making and monitoring is impossible. Outputs and outcomes cannot be measured, monitored or improved. Australians can only guess about the relative quality of their health system. They cannot hold their governments accountable for health system performance.<sup>30</sup> Duplication, high administrative workloads and waste of clinician and patient time are inevitable. Moves to implement more coordinated models of care are made more difficult.

'Health care is in a state of data overload. It urgently needs to be able to extract, integrate and share the right information to the right people at the right time.'

Australia's progress in developing comprehensive health information systems is slower than that achieved elsewhere despite the early start, the years of work and the level of investment already made.

'From being an early leader in its ability to manage and use health information, Australia is now increasingly falling behind comparable countries such as the UK, Canada and the USA'.

Neither informed purchasing nor funding policy change is possible. Australians cannot make informed decisions about their choice of provider in ways that their counterparts in other countries can, where reporting performance outcomes by institution and clinician is considerably more advanced.

Funders cannot move to a system of paying for results rather than activities, as done elsewhere to reorient health spending to needs and outcomes.

'... our health data content requires attention and its collection, storage and accessibility present multiple barriers to constructive reporting and system monitoring. All our major systems are set up as provider-payer and/or episodic service repositories, rather than 'person-centred' information sources. As a result we are unable to match the performance management of the system to performance expectations.'

The three quotations in this section are sourced from page 75 of the PricewaterhouseCoopers submission to the National Health and Hospitals Reform Commission.

#### ***3.4 The added effects of industry structure and limited competition***

The combination of a bureaucratised public sector, a heavily regulated system and low industry concentration in the private sector, together with few international competitive pressures,<sup>31</sup> and a system that funds providers rather than patients or patient outcomes, means that many of the forces for improved safety, quality, efficiency and productivity in other parts of the Australian economy have not been felt in the health sector. Although bodies such as the Productivity Commission have found it difficult to assess productivity improvement within the health sector, most believe it is lower than in other sectors, and certainly the sector's costs are rising more quickly. Australia's productivity improvement program must include all parts of the economy to ensure efficient and effective allocation of resources.

While not suggesting that health must be viewed as a business, there are many elements within the health sector that employ business processes and many issues, such as patient flow and patient experience, that can benefit from the application of business-like practices.

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There is scope for improved safety and quality of outcomes for patients, greater efficiencies and improved staff and patient satisfaction.

For example:

- The roles, scope and hours of work of health professionals remain much as they have been despite the changes in training, access to new technologies and demands for changed patterns of service.<sup>32</sup>
- The concept of valuing a patient's time, in the same way that commuter time is regularly factored into assessments of cost-effectiveness in the transport sector, rarely appears, and patient satisfaction surveys, where present, are underdeveloped. The development of multidisciplinary clinics offers opportunities to improve the patient experience, reduce waiting and travel times and shorten communication lines between health professionals, reducing the elapsed time from presentation to treatment and reducing demand in emergency departments.<sup>33</sup>
- The Victorian Auditor-General found that bottlenecks in patient flow in five large public hospitals had caused extended waiting times for patients. A computerised bed management system eliminated the problem.<sup>34</sup>
- The New South Wales Health Clinical Service Redesign Program (CSR) is focusing redesign of processes from the perspective of the patient journey. Managing that journey, as opposed to the component services within major institutions, means eliminating waiting times and minimising movement. Redesign of the facilities to reflect those flows is part of the enabling infrastructure. The redevelopment of the Royal North Shore Hospital in Sydney provides an example of such design.
- The New South Wales Auditor-General has reported that the cost of treating patients outside the hospital system through out-of-hospital programs is roughly half that of in-hospital treatment, and that up to 10 per cent of current patient admissions might benefit from such treatment.<sup>35</sup>

Our argument is not that Australia's healthcare system has not achieved efficiency improvements nor incorporated innovations. Clearly it has, and without those achievements, our health costs would be considerably higher than they currently are. Cost containment and queuing measures, together with throughput targets, uptake of new medical technologies and specialisation of practice, have led to shorter hospital stays, substantial growth in day surgery, greater numbers of people being treated and greater consistency of outcomes.

The rate of growth in Australia's health costs is less than in many other OECD countries.<sup>36</sup>

Rather, we believe that the continued use of blunt efficiency tools, such as budget capping and restriction of training places, is unlikely to deliver the extent of efficiencies and quality outcomes that Australians seek. Although Australian health providers have been among early adopters of new medical technologies, systemically Australia lags OECD averages on technology availability.<sup>37</sup> Generally, diffusion of innovation is slow and dependent on voluntary take-up by individual practices or institutions. The examples above suggest there is scope for further efficiency improvements, but achieving them will require more sophisticated and systematic approaches to both process improvement and uptake of innovative practices. A patient-focused approach that factors in patient time and satisfaction will accelerate the rate of change.

One area of special note is the lack of urgency with which issues of quality and error have been addressed in the health sector. In most other sectors, be they goods or services, ranging from air travel to manufacturing, the elimination of adverse events and rework have been the subject of considerable organisational reform effort. Whether motivated by concerns to eliminate unnecessary deaths, injuries or costs, most sectors have experienced sustained and detailed changes to operating processes and/or outcomes that have lifted safety and quality outcomes and improved efficiency. The foundation Australian study in 1995 on patient safety estimated that up to 16.6 per cent of hospital admissions were associated with an adverse event, adding between \$1–2 billion in unnecessary costs to the health system. The most recent report shows 5.5 adverse events per 100 public hospital separations and 4.8 per 100 private hospitals – some 352,963 cases in all. Of these, 2 per cent (7059) resulted in serious injury or death.<sup>38</sup> Yet, despite the size of the problem and known solutions, action remains uncoordinated and largely voluntary.<sup>39, 40</sup> Implementation of a nationally consistent monitoring system of performance by institution and clinician lags behind those systems already available in other countries.

In summary, Australia's capacity to adapt is limited by the complexity and fragmentation of its health system, blurred accountabilities and the lack of a nationally consistent and useful information system. It also lacks 'future-scanning' systems that would allow the anticipation of new health threats or innovations to improve system efficacy.

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Many structural and process changes are needed to adapt the current system to the nation's changed health needs and to do this in an efficient, timely way that puts patient value and outcomes at the centre of reforms. The NHHRC must address these in a systematic way if it is to succeed in breaking the current impasse in health strategy-making.

Furthermore, the structure of the health sector, dominated by dispersed and numerous private sector providers and large bureaucratically run public providers, and a lack of international competition, has meant that many of the pressures for quality and efficiency improvement experienced in other sectors have not been felt in this sector. There appears to be scope for extending the efficiency improvements that have been made by adopting mechanisms used in other sectors, without jeopardising patient safety or universal coverage.

## PART 4: WHAT ARE THE PREREQUISITES AND PRIORITIES FOR CHANGE?

The capacity to implement a new national health strategy is totally dependent on tackling the systemic constraints identified above. Without a new governance system and revised funding arrangements, we will not have a national health system that can address, in a timely, effective and affordable way, the current and projected disease burden as the population ages. We therefore believe that the following six areas must be tackled and deadlines set as a matter of urgency.

### *4.1 New and independent leadership: establish a clear point of leadership and accountability for developing, implementing, monitoring and updating the national health strategy*

First and foremost, a point of authoritative and accountable leadership must be established to develop the strategy, lead its implementation schedules and plans, allocate accountabilities, establish and monitor performance milestones and indicators, and report transparently on both the reform progress and progress towards the overall goal of improving the health of Australians.

In our view, this can only be procured through the establishment of an independent health body that will integrate the different jurisdictions and forms of provision, allocate clear accountabilities, and establish and monitor the attainment of measurable targets. This body should be independent of the political cycle, but accountable to the political process. Its processes should be transparent and it should be accountable to governments. It should not add an extra layer to the already large and numerous health bureaucracies, but rather, oversee accountable and clinical governance at the provider level. Local boards, fewer layers of management and emphasis on key performance metrics would provide greatly needed transparency and accountability to the system.

The primary functions of this body are to steer the system through establishing accountabilities, measurable targets, monitoring systems and funding mechanisms to cost-effective delivery of services that will improve Australia's health. It will ensure that future scanning identifies changing disease patterns, and their causes, and new technologies and models of care that can improve health and cost-effectiveness. It will be the market regulator, assuring the Australian community of the quality of the system overall and of individual providers. It will establish funding arrangements that will encourage innovation and the take-up of best practice in both clinical and business processes.

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#### SUGGESTED FUNCTIONS OF AN INDEPENDENT HEALTH BODY

Establish a clear accountability for leading a national health strategy that addresses the current and projected pattern of disease and its determinants. Its functions should include:

- Identifying needs and best fit services to meet these, including preventative health initiatives. This implies best-practice clinical research input, technology assessments and scanning. It also implies liaison with clinical training providers as skills and competencies change.
- Purchasing/funding arrangements for provision: a mix of activity and performance-based funding to create incentives for new models of health promotion, detection and care and new types/configuration of facilities. (This will require cross-portfolio liaison with the housing, aged care and community services sectors.)
- Accreditation of providers able to receive funding (franchise model) – quality standards for providers (organisations and professional staff); specification of common systems or connectivity standards to permit patient, performance, outcomes and cost data provision between parts of the system and extracted to a national data set.
- Identification and publication of key metrics (say, 12) on the performance of providers and of the system, including patient satisfaction.

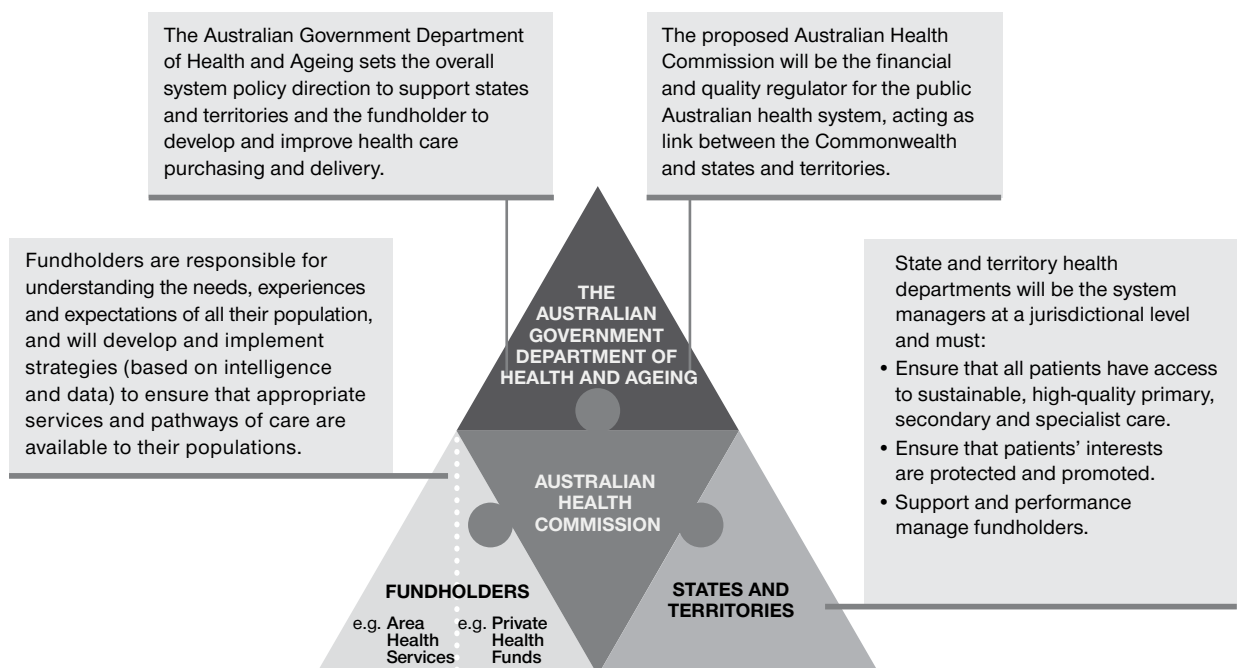
The establishment of such a body may not be an end in itself. The NHHRC has proposed three alternative structural models. The independent commission outlined above could well be the first stage in a process that moves the health system towards the NHHRC's Options B and C. The point is that one body must be provided with the authority to plan, lead and develop the new system and to break the current impasse. In our view, the initial planning, funding, information and quality systems set-up and implementation will take five years. We are also cognisant of the possibility for unintended consequences in seeking to adapt a complex system. A staged process of change allows for the monitoring of the effects of changes, adjustments as a result, prior to moving to the next stage.

#### RECOMMENDATION

As a first step, establish an independent body responsible to the Commonwealth and state governments to oversee the development of a national health system that promotes a healthy population, encourages cost-effective service provision models that meet current and emerging health needs and monitors the quality, safety, efficiency and effectiveness of service provision.

An example how the system might be configured:

#### SYSTEM MANAGEMENT STRUCTURE



Source: © PricewaterhouseCoopers, May 2008.

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#### 4.2. New funding arrangements

Funding schedule and incentive changes to encourage different behaviours by citizens/patients and their agents, service providers, administrators and employers are essential and need to be a high priority for the new body. The current funding systems (public funding and provision of hospitals and services); the Medical Benefits Schedule which buys clinician time, judgment and procedure; and the Pharmaceutical Benefits Scheme, which subsidises patient purchase of drugs and devices are all important elements in ensuring universal access to health services and the maintenance of a health infrastructure. However, the current structures of these systems reflect past patterns of disease and their treatment models, and tend to be input-focused rather than outcome-focused. Changes to incorporate new patterns of care and more value-conscious patterns of health consumption alongside the need for continuation of episodic and universal care are needed. In making the changes, the schedules need to be simplified, obsolete practices removed, and the basis of costing be set at the best clinical practice within an efficient environment.

Adoption of the following financing principles, many of which have been explicitly proposed by the NHHRC, would accelerate the reconfiguration of both service provision and individuals' behaviour:

- Combine federal and state funding to reduce the plethora of programs.
- Separate purchasing and provision decisions to extend the purchasing of public services from private and NGO providers to supplement public providers and provide some limited competition. This is especially important in the areas of new services where existing facilities and services have not yet been established.
- Purchase on the basis of the mix of services and treatments projected by a mix of geography and patient group to reorient the system to new patterns of prevention, early detection and treatment, based on known and current needs and taking account of associated costs of access and ongoing treatment, such as transport and pharmaceuticals.
  - Patient-based funding for chronic care services.
  - Case-mix funding for acute inpatient and ambulatory<sup>41</sup> settings.
- Purchase price to be determined on the basis of best clinical practice within an efficient environment to encourage the take-up of best practice in both clinical and business processes and to increase quality and efficiency.

- Bonuses to be paid for outcomes achieved (volume, low re-admission, effectiveness of treatment) to accelerate the improvement of quality and safety improvements.
- Purchasing from accredited providers only to protect quality of the system (see 4.4).
- Transparency in costs per treatment and co-payments by patients for ongoing treatment (subject to a safety net) to encourage value-conscious behaviour by patients (especially in cooperation in participating in preventative and self-management measures).
- Coverage across all health-related services to acknowledge the holistic nature of physical and mental health requirements. For example, the current separation of oral health and partial separation of mental health from the health system through exclusion from the MBS does not make sense.

#### RECOMMENDATION

Change the financing systems in accordance with these principles as a means of encouraging changed behaviours, reconfiguring systems, improving the quality of outcomes and the efficiency of provision while extending the arrangements to incorporate all aspects of physical and mental health and ensuring the maintenance of a safety net to guarantee access. This comprehensive funding review should be undertaken as a top priority by the independent health body, with recommendations to be implemented for the 2010–11 financial year.

#### ***4.3 Implement patient-based information systems and communication systems that build connectivity between disparate parts of the system and comprehensive data to support coordinated care, clinician support, system planning and monitoring***

There is widespread agreement that investment in integrated and patient-based information systems, building upon personal e-health records, is critical to improving both clinical treatment for patients and business process improvements. This is the fundamental building block to support improvements in quality outcomes for patients, improved decision-making by clinicians and policymakers, and efficiencies. It is also fundamental to enabling accountability for the performance of the system.

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A revised strategy must be put in place by the end of 2009, taking account of the reasons that the investment and action to date have not delivered the promised results. Specifically, the new independent health body must:

- Establish a cross-sector platform for sharing clinical histories and patient information.
- Create value-added services that support clinicians across settings to reconcile, plan, diagnose and refer care.
- Increase support for, and remove barriers to, telemedicine and remote consultation, especially in remote areas.
- Improve clinical research and population health research through deeper analysis of aggregated data.
- Empower frontline clinicians with 21st-century technology to enable remote access and collaboration.
- Implement a national scorecard/reporting/evaluation platform applied across the acute, community and primary care sectors.
- Standardise key performance indicator definitions and benchmarks.

#### RECOMMENDATION

Develop, as a matter of urgency, a national patient-based information system to underpin patient care and clinical decision-making, practice-based research and evaluation, and system planning and monitoring.

#### **4.4 A quality accreditation framework for providers**

The establishment of quality assurance in professional settings generally relies on the accreditation of the professionals and the settings or institutions within which they undertake their work. The current system of accreditation of professionals in Australia has been an important element in providing assurance to the community that professionals have the skills, knowledge and competencies to undertake their work. However, registration has been state-specific and relied on the advice of the specialist colleges. These systems have allowed the movement of those not competent to move between states. It has also embedded traditional roles and scope of work, even as the training within professional areas has changed.

The national accreditation and registration system agreed by Australian governments for implementation in 2010 addresses both of these issues. In doing so, it not only plugs current gaps in quality processes, it also provides a means by which the roles of providers can be diversified but within a quality system. This represents a major opportunity for offsetting some of the skill shortages and distribution issues identified in this paper.

The current trials established by COAG for nurse practitioners and physician assistants are examples of the kinds of new roles that may emerge. Concerns about the quality assurance of their work must be addressed and the kind of competency-based assessments proposed by the NHHRC may be one solution. Other industries, such as the aviation industry, have also grappled with the issues of quality assurance within and outside supervised practice and may provide other, or supplementary, models. Certainly, one of the challenges within the current health system is how to monitor ongoing practice competency, particularly in the absence of performance data.

For this reason the second part of the quality assurance framework must incorporate a strong and nationally consistent accreditation of institutions. As recommended in 4.1, assurance of quality to patients and the community at large must be a fundamental and urgent task of the new health body. Accreditation that allows providers to operate must be firmly based in a quality framework that adopts a risk management approach, open disclosure and clear monitoring and performance reporting. The accreditation process can also be used to identify the information and systems interoperability that will speed patient journeys, reduce errors, improve outcomes and enable efficiencies. Current arrangements are patchy and not universally a condition of funding, although many of the associated processes have introduced the key concepts. These must now be extended to drive improved quality outcomes and system connectivity and efficiency.

#### RECOMMENDATION

Establish a two-part quality assurance process that accredits both professionals and providers and drives improvement in quality outcomes by making accreditation a condition of funding and the right to operate.

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#### 4.5 Workforce and skills

Ensuring the right size, composition and geographic distribution of health professionals have been identified as a key set of challenges facing the system. Others have already reported in detail about the sources of the problems and the potential solutions.<sup>42</sup> From these reports it is clear that a multi-pronged approach to building the workforce of the future is required, incorporating new education and training arrangements, new avenues of specialisation, continued reliance on international recruitment and changes to workforce roles, scope of work and ways of working. It is also clear that again the split accountabilities for the health workforce between state and Commonwealth governments has prevented a comprehensive strategy being established. The decision by the Council of Australian Governments (COAG) to implement a national accreditation and registration process from the year 2010 is to be applauded. However, this is a first step that must be quickly built upon, albeit within the quality framework identified above. The lessons from other sectors show how added flexibility and deployment can add both to productivity but also greater job satisfaction. Those lessons also show that while some embrace such change, many do not. The challenge for the health body charged with building the workforce of the future is to rise above existing boundaries and to clearly identify the operating and quality requirements of the new health system and ensure a ready supply of appropriately trained people to meet those requirements.

#### RECOMMENDATION

To ensure the supply of adequate numbers of appropriately skilled health professionals to meet the needs of the reconfigured health system, the proposed new independent health body must build strongly on the agreements reached to date for health workforce training, accreditation and role redesign.

#### 4.6 Building understanding: engagement of the community and constancy of purpose

The manner of change will be as important as its content. While the language of reform, in government publications and in this paper, inevitably follows a managerial bent, the design and implementation of new models of care, clinical processes and the identification of best practice (but efficient) treatments must be led by clinicians.

International experience suggests that effective forms of clinical governance must be restored if the system is to deliver effectively. However, business process expertise must sit alongside this, providing mechanisms and processes that will encourage the implementation of efficient and effective utilisation and scheduling systems, billing systems, monitoring and costing systems. Certainly, greater accountability and performance indicators are an essential part of such a system, but which are the indicators that will promote the health outcomes and financially sustainable system we seek? Process redesign can deliver improvements in efficiency, quality outcomes and patient satisfaction, but the nature of those processes must reflect the best-practice clinical treatment procedures and protocols. A pooling of, and mutual respect for, different professional expertise is required.

There is also a very strong need for public engagement. International experience again suggests that the program will fail unless there is widespread public understanding of the need and support for the nature of the changes. Because of the extent of the change required and because of the centrality of a cost-effective and accessible health system to quality of life, the public cannot be left out of the current debates, nor left to wonder about the effectiveness and rationale for proposed changes. A major communication campaign about the need for change and the changing responsibilities for health management will be needed to ensure that the changes are publicly supported.

It is also important that the messages of improving health are consistent across government policy areas. We have already stated that addressing many of the determinants of the current disease pattern will fall to agencies beyond health, such as planning, environment, transport, workplace, and emergency services agencies. It is important that as these agencies pursue their own policy agendas they reinforce the messages of health and take opportunities to promote health and preventative health measures.

#### RECOMMENDATION

Adopt best-practice change management by:

- Involving all relevant expertises and perspectives in development of plan at each level.
- Making milestones and progress transparent.
- Aligning incentives across government portfolios.
- Pacing the change and resourcing it appropriately.

## PART 5: CONCLUSION

The Australian health system has delivered significant improvements in health outcomes for many Australians. But it is a system under pressure, often maintained only through the commitment of those at the front line, and one that faces major challenges of adaptation and financial sustainability. Concerted and sustained effort to adapt the system and relieve the existing pressures and inequities in the system must begin now.

Without systemic change, our health status as a nation will decline and our social and economic prosperity will suffer. Health reform is an important part of the ongoing reform agenda and should not be delayed by short-term imperatives. Improving the health status of Australians is an important element in building for future prosperity and sharing it more evenly among Australians.

The adaptation required as the nature of Australia's disease burden changes cannot be overstated. It requires a major reconfiguration of physical, information and human resources that can only be achieved through a major overhaul of the governance, funding, information and quality assurance components of the healthcare system. The priorities should be first, to promote health and wellbeing and prevent ill health and second, to implement new cost-effective models of care to reflect the needs associated with different groups and communities.

The clear pressures and systemic failures associated with the current system show that we must tackle this adaptation urgently. But it will also require a long-term vision, sustained effort and investment. First and foremost, the adaptation must be guided by a shared vision of what is needed and why, and an inclusive leadership that drives the implementation of that vision.

The interim report of the NHHRC outlines many of the reform directions that health professionals agree must be adopted. However, in developing its final report, the NHHRC needs to locate these directions clearly within a new and comprehensive national health strategy. That strategy must address the current and projected disease burden and its determinants within a structured framework that aligns the demand for and the provision of services. That framework must be clear to the community at large. Only in this way can we develop confidence that we can achieve improved health for all, within a clinically and financially sustainable system.

This is not a bureaucratic exercise. It is a change process that involves all of us. Health is everybody's business.

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## NOTES

- 1 This paper draws on work presented by BCA member companies in submissions to the National Health and Hospitals Reform Commission in 2008: Accenture, *Submission to the National Health and Hospitals Reform Commission*, September 2008; Australian Unity, *Submission to the National Health and Hospitals Reform Commission*, May 2008; PricewaterhouseCoopers, *National Health and Hospitals Reform Commission Submission Response: Governance, Accountability and Coordination – The Keys to Person-Centred Health Care*, May 2008. That work is gratefully acknowledged.
- 2 In estimating the effects on society and the economy, the total disease burden, rather than deaths alone, is relevant. That burden includes premature deaths, together with estimates of the losses from disease through to disability or reduced functioning.
- 3 Australian Institute of Health and Welfare (AIHW), *Australia's Health 2008*, Canberra, 2008.
- 4 Chronic diseases are those illnesses that are long in their development or longstanding in their symptoms. Some can be immediately life-threatening (e.g. heart attack or stroke); others are serious but not necessarily terminal (e.g. cancer, depression, diabetes). They are not new, with some (e.g. diabetes and arthritis) being known for over a century, but they have increased in prevalence as the significance of infectious diseases has reduced and the population has aged. They affect all ages. (AIHW, *Chronic Diseases and Associated Risk Factors in Australia*, AIHW Catalogue No. PHE81, Canberra, 2006.)
- 5 AIHW (2008), op. cit., Chapter 2.
- 6 ABS, *Key National Indicators 2007*, ABS Catalogue No. 1345.0, Canberra, 2007.
- 7 AIHW (2006), op. cit., p. 35.
- 8 AIHW, op. cit., p. 335.
- 9 National Preventative Health Taskforce, *Australia: The Healthiest Country by 2020*, Discussion Paper, Canberra, 2008.
- 10 Productivity Commission, *Economic Implications of an Ageing Australia*, Canberra, 2005.
- 11 Victorian Government, *A Third Wave of National Reform: A New National Reform Initiative for COAG*, Melbourne, 2005.
- 12 Australian Bureau of Statistics, *Health of Mature Workers: A Snapshot 2004–5*, Ref. No. 4837.055.001, Canberra, 2008; Dame Carol Black's Review of the Health of Britain's Working Age Population, *Working for a Healthier Tomorrow*, Report to the Secretaries of State for Health and for Work and Pensions, London, 2008.
- 13 Presenteeism can be defined as the loss of productivity that occurs when employees come to work but 'self-report' they are not fully functioning because of illness or injury.
- 14 Aegis Consulting on behalf of the Health and Productivity Institute of Australia, *Using the Workplace to Prevent Chronic Disease*, Submission to the National Health and Hospitals Reform Commission, Canberra, 2008.
- 15 Commonwealth Treasury, *Intergenerational Report 2007: Frameworks for the Future*, Canberra, 2007; Productivity Commission, *Economic Implications of an Ageing Australia*, Canberra, 2005.
- 16 For example, New South Wales; see New South Wales Auditor General, *Performance Audit: Out of Hospital Programs*, Sydney, 2008.
- 17 National Preventative Health Taskforce (2008), op. cit.
- 18 C. Jones, 'More Life v. More Goods: Explaining Rising Health Expenditures' in *FRBSF Economic Newsletter*, No. 2005–10, May 2005.; J. Richardson, *Steering Without Navigation Equipment: The Lamentable State of Australian Health Policy*, Working Paper 2008–33, Centre for Health Economics, Monash University, 2008.
- 19 Productivity Commission, *Economic Implications of an Ageing Australia*, Canberra, 2005.
- 20 PwC, op. cit., p. 59.
- 21 PwC, op. cit., p. 40.
- 22 AIHW (2008) *Australia's Health 2008*, Canberra, 2008: Some 32 per cent of medical specialists and 29 per cent of primary care clinicians were aged over 55 years in 2005, and the proportion of nurses aged at or over 55 years doubled to 20 per cent between 1999 and 2005. Although the number of employed medical practitioners had increased by 25 per cent between 1997 and 2005, the effect of reduced hours and population growth led to an overall increase in access from only 275FTE/100,000 population to 287FTE/100,000 population. In 2006 there was a shortage of nurses of between 10,000 to 20,000 and a shortage of 10,000 to 13,000 is projected for 2010. Despite the recent increased investment in university-based medical education, AIHW still projects a shortage in primary care clinicians and Australia lags behind other OECD countries in the number of physicians per capita.

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## NOTES

- 23 OECD, *Health Data 2008 – How does Australia Compare?* 2008, [www.oecd.org/health/healthdata](http://www.oecd.org/health/healthdata).
- 24 *Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, 2008* (report of the Garling review).
- 25 P. Curson, 'Human Health, 'Climate and Climate Change: An Australian Perspective', Chapter 12 in T. Giambelluca and A. Henderson-Sellers, (eds) *Climate Change: Developing Southern Hemisphere Perspectives*, John Wiley & Sons, 1996.
- 26 Recent initiatives within COAG have started to move the system but they have not yet provided an overall roadmap that all can understand.
- 27 Many believe (e.g. Garling review) that the growth in demand in hospital emergency departments is linked to a desire by patients for a one-stop-shop, and/or a lack of understanding on how to navigate the system.
- 28 PwC, op. cit., p. 23.
- 29 The process for distributing funds to public hospitals and health providers differs between states. In some states there are clear activity-based funding systems (e.g. case mix); in others, block funding based on historical budgets is provided. In no case is funding based on outcomes or in ways that incentivise ongoing care, although data on the number of re-admissions is starting to be collected.
- 30 Australian Unity, op. cit.
- 31 Draws on IBISWorld, *Health and Community Services in Australia*, Industry Report, Melbourne, 2008.
- 32 For example, many industrial instruments assume a 9 to 5 working week with penalties and other arrangements to deal with what are effectively 24/7 operations. Many facilities are not utilised because of the working hours of practitioners. One report even notes that the traditional timing of morning rounds by specialists in hospitals at 10.00 am prevents early discharge of patients and speedier admission of new patients.
- 33 PwC, op. cit., p. 73.
- 34 Auditor-General of Victoria, *Managing Acute Patient Flows*, Melbourne, 2008.
- 35 New South Wales Auditor-General, *Out of Hospital Programs*, Sydney, 2008.
- 36 OECD (2008), op. cit.
- 37 *ibid.*
- 38 AIHW (2008), *Australia's Health 2008*, Canberra, p. 356.
- 39 Australian Commission on Safety and Quality in Health, *Windows into Safety and Quality in Health Care 2008*, Sydney, 2008.
- 40 The most recent review, the Garling review in New South Wales, recommended immediate structural and procedural changes to establish and maintain a robust process for monitoring the quality of clinical performance, the quality of the patient experience, the cost-effectiveness of treatment regimes and the sustainability of process improvements, including regular staff satisfaction surveys (p. 55).
- 41 According to a definition used by the Australian Institute of Health and Welfare, ambulatory conditions are those for which, in theory, hospitalisation is thought to be avoidable in 'ambulatory' settings, which include primary health care such as general practice, community care, emergency department care and outpatient care.
- 42 For example, Productivity Commission, *Australia's Health Workforce*, Canberra, 2006.

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