

**Notes to inform Health Consumers Queensland's response to the
Australian Government's National Health and Hospitals Reform Commission report -
*A Healthier Future for All Australians: Interim Report December 2008***

Introduction

The terms of reference for the National Health and Hospitals Reform Commission (NHHRC) include provision of advice to the Australian Health Care Agreements by April 2008, and a report on a long-term health reform plan by June 2009. The NHHRC hopes to address concerns about inefficiencies generated by cost-shifting, blame-shifting and buck-passing; and integration and coordination of care across all aspects of the health sector, especially between the primary care and hospital sectors. The NHHRC wants to bring a greater focus on prevention; better integrate acute services and aged care services and improve the transition between hospital and aged care besides improving frontline care towards healthier lifestyles and the prevention and early intervention of chronic illness. Especially, the NHHRC is keen to improve the provision of health services in rural areas; Indigenous health outcomes; and ensure a well-qualified and sustainable health workforce into the future.¹

The NHHRC developed a set of principles to guide reform and future directions of the Australian health system. The design principles, as follows are an indicator of what citizens and potential consumers want from their health system:

- People and family-centred
- Equity
- Shared responsibility
- Promoting wellness and strengthening prevention
- Comprehensiveness
- Value for money
- Providing for future generations
- Recognising that broader social and environmental influences shape our health.

The governance principles indicate how the NHHRC believes the health system should work, as follows:

- Taking the long-term view
- Quality and safety
- Transparency and accountability
- Public voice and community engagement
- A respectful, ethical system
- Responsible spending
- A culture of reflective improvement and innovation.

The principles can be accessed at:

<http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/principles-lp>

¹ National Health and Hospitals Reform Commission. (2008). Terms of reference. On 1 February 2009, downloaded from: [http://www.health.gov.au/internet/main/publishing.nsf/Content/619A18D684E8AFFDCA2573FE0005089D/\\$File/Terms%20of%20Reference.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/619A18D684E8AFFDCA2573FE0005089D/$File/Terms%20of%20Reference.pdf)

The, *A Healthier Future for All Australians: Interim Report December 2008* was preceded by the National Health and Hospital Reform Commission's (NHHRC) first report, *Beyond the Blame Game* in April 2008. That report provided a long-term view to inform negotiations around the *Australian Health Care Agreements* and likely reform directions, performance indicators and benchmarks. It can be accessed at: www.nhhrc.org.au

The National Health and Hospitals Reform Commission's (NHHRC) interim report looks at the key issues that impact on the planning, delivery, funding and organization of health services in Australia. The focus is on long-term outcomes for Australians and the maintenance of the principles of universality of Medicare, the Pharmaceutical Benefits Scheme and public hospital care. The report offers clear reform directions in some areas and provides options and suggestions for others, where further input is desirable. Consultations with health consumers, health professionals, hospital administrators, State and Territory governments and other stakeholder stakeholders will inform further work and proposals. The report emphasizes four strategic reform themes:

- Taking responsibility – individual and collective action to build good health and wellbeing
- Connecting care for people over their lifetime – with a strong focus on strengthening primary health care
- Facing and addressing health inequities
- Driving quality performance.

According to media, the landmark report has “won over consumers, but been challenged by doctors and the states, which face a federal takeover of their health services.”² In essence, the report has proposed a new division of responsibilities between the state/territory and federal governments; health consumers; health workers; and health professionals. In this media article, Carol Bennett (Consumers Health Forum Executive Director) recognized the importance of shifting the debate from bureaucracy to health consumers and health consumers having involvement in reforming the current health system and real options for needed and accessible health services and better health outcomes for all Australians. A key mantra of the Commission is keeping “people and families at the centre” and listening to the lived experiences of those within the health system.³

Report synopsis

The report is divided into 15 chapters, providing insight on particular health populations and issues.

Chapter 1 focuses on the theme, *Taking Responsibility* and how individuals and collectives of citizens can work towards building good health and wellbeing. The chapter highlights the importance of healthy communities as central to economic development and poverty reduction, with prosperity linked to better health, greater productivity and higher labour force participation. Key messages in the chapter suggest health is everybody's business but despite universal entitlement to health services, some groups, particularly Aboriginal and Torres Strait Islander peoples and people with long-term disability, have unacceptably poor health status, low levels of literacy and reduced access to health services. ‘Vertical equity’ suggests ‘unequal but equitable access for unequal need’.

Prevention and health promotion underpins this chapter, acknowledging that health is influenced by personal health behaviours; social and economic factors; the built environment; employment; education; housing; early childhood development; clean air; and safe food and water. These social,

² Ryan, S. (2009). States and doctors uneasy. Article published in The Australian on 17 February, 2009.

³ Consumers Health Forum of Australia. (2009). Consumers the key to health reform. Media release on 16 February 2009.

economic and environmental determinants of health are the strongest predictors of people's health, structuring life opportunities and lifestyle choices. Broad complementary strategies to reduce health inequalities could be:

- Introducing targeted programs for disadvantaged populations
- Closing health gaps between worse-off and better-off groups
- Addressing the social health gradient across the whole population.⁴

All sections of Australian society have a role to play in boosting health promotion and prevention and ensuring appropriate assessment of the evidence on preventive interventions and readily identifiable funding mechanisms for these key areas. The NHHRC believes national action on social determinants and health inequity should be matched with local participation and action to tackle problems impacting on the health of local communities. A 'wellness footprint' that measures a range of factors contributing to healthy communities could be implemented, looking at:

- Dynamic, resilient local economies
- Sustainable built and natural environments
- Culturally rich and vibrant communities
- Democratic and engaged communities
- Healthy, safe and inclusive communities.⁵

The NHHRC suggests promoting health in our workplaces, beyond a traditional focus on workplace health and safety to include targeted wellness, health promotion, risk screening and self-management programs for workers, especially around chronic diseases. This reportedly, has an average cost benefit ratio of 1:6, with every dollar invested in the workplace generating a return of six dollars. Strategies could include government financial support for such programs; amending taxation provisions; changing private health insurance rules to promote health screening; and the development of a national wellbeing index with workplace health programs to capture the wellbeing of the working population.

In addition, the NHHRC suggests financial incentives can be effective in increasing the uptake of preventive health programs, especially when the focus is on positive behaviour reinforcement rather than financial penalty. Encouraging people to take greater responsibility for improving their own health, within their capacity, is a shared responsibility between individuals, their community of interest, service providers and government. The Australian Institute of Health and Welfare's research indicates 32 per cent of the burden of disease in Australia is due to seven preventable factors, including smoking, obesity, physical inactivity, excess alcohol consumption and personal behaviour.

Better health literacy would ensure health consumers and citizens have "the knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy."⁶

⁴ World Health Organization Commission on Social Determinants of Health. (2007). A conceptual framework for action on the social determinants of health: A discussion paper, downloaded on 2 March 2009 from: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

⁵ Measuring wellbeing: Engaging communities: Developing a community indicators framework for Victoria: The final report of the Victorian Community Indicators Project. (2006). Downloaded on 27 February 2009 from: http://www.communityindicators.net.au/system/files/20060817_VCIP_Final_Report.pdf

⁶ Australian Bureau of Statistics. (2008). Australian literacy and life skills survey: Summary results, downloaded on 2

Unfortunately, lower health literacy is associated with poorer health outcomes and lower rates of screening for preventable health conditions, poorer child health management and responsiveness to discharge instructions.⁷ The idea of promoting health literacy from kindergarten to high school and beyond was canvassed in a number of submissions to the NHHRC. Online resources, the media, general practitioners, non-government organizations, health departments and health insurers could contribute to ongoing information provision and education of health consumers.

Key reform directions identified

- Affirmation of universal entitlement to medical, pharmaceutical and public hospital services under Medicare and choice of and access to private health insurance. Disadvantaged groups need to be targeted for optimal health outcomes.
- The need for public and private reporting mechanisms on health status, service use and outcomes, especially relating to disadvantaged groups.
- Regular national health inequity reporting.
- The development of accessible health information on and the 'wellness footprint' of local communities.
- Existing regulatory barriers to increase the uptake of wellness and health promotion programs by employers and private health insurers should be removed.
- The need for *Healthy Australia* ten-year goals for health promotion and prevention with community ownership and commitment and regular progress reporting to government..
- The establishment of an independent national health promotion and prevention agency, responsible for national leadership on the ten-year goals and the building of capacity, infrastructure and evidence-based practice to inform the health care system.
- Developing policies that make healthy choices easier for individuals, families, communities, health professionals, employers and governments.
- Health literacy becomes a core component of the primary and secondary schools' national curriculum and skills assessment.
- Cross-sector, user-friendly and evidence-based information is accessible to support people to make healthy choices.

Chapter 2 looks at primary health care as the foundation of the health system. It asserts coordinated, continuous, responsive care across the life cycle should be the pillar for people needing care and treatment, especially where they experience chronic illness, disease, disability or frailty. Responsive primary health care, in local communities, is the gateway to health services, to ensure the right care in the right setting by the right health professional and to support health consumers to self-manage or prevent chronic conditions progressing. The NHHRC joins with the Department of Health and Ageing in proposing that primary health care policy and funding becomes the responsibility of the Australian Government, which should actively foster the widespread establishment of multi-disciplinary comprehensive primary health care centres across Australia. This would include facilitating access to care for communities not well-served by health professionals, a voluntary enrolment model and a system for person-controlled electronic personal health records.

March 2009 from:

[http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20\(Reissue\)?OpenDocument](http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4228.02006%20(Reissue)?OpenDocument)

⁷ Agency for Healthcare Research and Quality. (2004). Literacy and health outcomes: Evidence report/Technology Assessment No. 87, downloaded on 3 March 2009 from:

<http://www.ahrq.gov/downloads/pub/evidence/pdf/literacy/literacy.pdf>

Chapter 3 details the need to nurture and invest in a healthy start to life from pre-conception, with formative years providing the foundation for a person's health and wellbeing throughout life. Special mention was made of concerning levels of childhood mental health and socio-behavioural issues and increasing obesity, physical inactivity and chronic and complex diseases. The NHHRC proposes universal child and family health services provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring within the first three years of life. Where health or developmental issues are identified, the service will provide or identify pathways for targeted care and a care coordinator, associated with a primary health care service, who would coordinate a range of services for the child and his/her family. During the primary school years, the NHHRC suggests all children have access to a school nurse for promoting and monitoring the child's health, development and wellbeing.

Chapter 4 highlights the need for timely access to hospitals and safe care, while an in or out-patient. Special mention was made of access to 'elective' admissions, which in reality may be essential to remedy chronic pain, maintain mobility or have an improved quality of life. Too, many older people experience prolonged stays in hospital while awaiting residential care, because of a shortage of appropriate, available Commonwealth funded beds. Better interface between Commonwealth, state and territory responsibilities may alleviate these issues, as would better sub-acute services and transition care arrangements. The NHHRC also identified issues where residents of aged care facilities need to be hospitalized. The NHHRC suggests some people are sent to hospital because of inadequate care in the residential facility by staff or visiting health professionals; or sent later than they needed to be; or experience adverse outcomes from their hospital treatment, which could have been better provided 'in place'. In addition, the NHHRC points out the paucity of good communication, reliable information and continuity of care between hospitals, non-hospital settings and health consumers.

The NHHRC identifies improvements in other parts of the community and aged care continuum as vital to reducing the current pressure on hospitals and the wise use of finite resources. The NHHRC also suggests improved integration and best use of the current system of public and private hospitals. The NHHRC further proposes national access guidelines for planned procedures and national access targets for emergency care, incorporating clinical, economic and community perspectives; financial incentives to reward good performance in outcomes and timeliness of care; the use of activity-based funding for public and private hospitals using case mix classifications; and a review of needs-based ambulatory services, particularly in community settings. To improve quality and accountability, public reporting against national sets of indicators would measure access, efficiency and quality of care provided through clinical leadership within hospitals and broader health settings. As part of routine feedback, the voices of health consumers should be listened to.

Chapter 5 looks at ways to restore people to better health and independent living, recognizing sub-acute care as vital in the consumer's journey. Services delivered, preferably in community settings, would include rehabilitation, geriatric evaluation and management, transitional care and step-up and step-down programs. The NHHRC proposes investment in sub-acute services infrastructure be one of the top priorities for the Health and Hospitals Infrastructure Fund; the right workforce available and trained to meet growing demand for sub-acute services; and the vital role of equipment, aids and other devices in helping people to improve health and social functioning.

Chapter 6 focuses on increasing choice in aged care, which needs to become more responsive to the needs and interests of older people and their families. Choice of aged care facility is high on the agenda, especially with low vacancy rates meaning some people have very little choice of residence. The NHHRC suggested the focus of aged care in the future should be on funding people and their needs rather than places. Of note, is the NHHRC proposal that the limit on provision of aged care

subsidies is changed from places per 1000 people aged 70 or more to care recipients per 1000 people aged 85 or over; and their suggestion of accommodation bonds or alternative approaches for people entering high care. As an alternative to residential care, the NHHRC proposes more flexible care subsidies for people receiving community care packages and that for financially advantaged consumers, contributions for community care equate with those for residential care. The NHHRC argues that aged care needs to be more responsive to older peoples' needs for improved quality of life in aged care and the productivity and efficiency of aged care delivery, with an increased supply to meet anticipated demand.

Chapter 7 looks at caring for people at the end of life and the specialist services needed and readily accessible in the community and people's homes. The NHHRC suggests the direct support of specialist palliative care services is only needed for a relatively small number of dying people and sometimes it is only available at a relatively late stage, whereas there are inherent benefits in consumers accessing these supports much earlier on. In addition, the NHHRC states there is good evidence that advance care planning can assist people's choices and the degree of control they maintain over their dying and where they die. The NHHRC proposes building the capacity and competence of primary health care services to provide generalist palliative care support, greater educational support; and improved collaboration and networking with specialist palliative care service providers for dying consumers. It was also proposed that funding be provided for the national implementation of the *Respecting Patient Choice Program* across all residential aged care services and that health professionals develop greater awareness through education of the common law right of people to make decisions on their medical treatment, including the right to decline treatment.

Chapter 8 focuses on closing the health gap for Aboriginal and Torres Strait Islander peoples. It was identified that this cohort are under-serviced and has poor health, with high levels of morbidity and life expectancy 17 years lower than other Australians. The NHHRC believes a whole of government commitment is required to address the social determinants of health, as well as improving health services to potentially close the gap by 70 per cent. Culturally sensitive, responsive and focused health care can help to close the gap by assisting with maternal and child health; quality care during life transition times, and the management of chronic disease. The NHHRC identified Aboriginal Community Controlled Health Services as important in the delivery of comprehensive primary health care, and maximizing people's potential and ameliorating illness as a barrier to this cohort's participation in family, community and workforce. Additionally, the NHHRC suggested increased involvement by this cohort in professional health training and an accreditation process for health services and education providers to incorporate core, specific Indigenous modules in all their training.

Chapter 9 looks at the delivery of better health outcomes for remote and rural communities whose health outcomes worsen with remoteness. The NHHRC believes locally designed and responsive primary health care services are the foundation of accessible quality health care for people in remote and rural areas, with flexible funding arrangements to reconfigure services to best meet district needs. This encompasses the provision of tele-health services, an on-call 24-hour telephone and internet consultation line, responsive patient travel and accommodation assistance, emergency care, retrieval services, repatriation, and community-based health professional services for continuity of care.

Chapter 10 is about supporting the large cohort of people living with mental illness in Australia, adversely affecting up to half the population during their lifetime; and addressing the stigma attached to the condition. The NHHRC suggested 65 per cent of people who need mental health care go untreated with adolescents and young adults particularly reluctant to seek appropriate treatment or supports. The NHHRC believes mental health spending should be shifted towards prevention and treatment and social support services beyond clinical care with emphasis on co-morbid alcohol and

drug dependency and other chronic illness or impairments. The NHHRC is proposing greater investment in mental health competency training; a national youth friendly community-based service which provides information and screening for mental disorders and sexual health with appropriate referral for those young people requiring more intensive support; the implementation of the Early Psychosis Prevention and Intervention Centre model as the norm; a rapid response outreach team in every acute mental health service; hospital-based mental health services being linked to multi-disciplinary community-based sub-acute services that support stepped prevention and recovery care.

Further, the NHHRC proposes the inclusion of mental health consumers and carers in policy development and service planning, implementation and evaluation to provide the consumer perspective. Also, the provision of stable housing for persons experiencing severe mental illness and greater investments in social support services is required to ensure re-connection with community with emphasis on post-discharge housing and appropriate domestic arrangements in place. The mental health of older Australians, particularly those living in residential aged care facilities should be provided for, through adequate access to mental health and dementia care services. In the matter of compulsory treatment orders, the NHHRC recommends cross-border recognition of these orders. From our observation, the paper does not include mental health care and treatment in the proposed comprehensive primary health care centres, and raises concerns about current presentation at hospital accident and emergency units and dedicated hospital-based mental health services. A recent mental health consumers and carers forum suggested, the culture of hospital mental health inpatient clinical service settings is often appalling and supports a system that is about incarceration rather than therapy or recovery.⁸

Chapter 11 emphasises the need to improve oral health and access to dental care. The condition of the mouth, teeth and gums affects consumers' overall health and wellbeing and their quality of life. Dental care means considerable out-of-pocket expenses for consumers, with many foregoing needed treatment in favour of more needed resources. 46.6 per cent of people on incomes less than \$20,000 delay dental care; 44 per cent of health care and concession card holders avoid or delay dental care; 42.7 per cent of non-insured people delay or avoid dental care; and 37.9 per cent of Aboriginal and Torres Strait Islander peoples delay or avoid dental care.⁹

The absence of early intervention practices has seen an increase in preventable oral conditions. However, waiting lists for assessment and treatment in public dental services have blown out to on average, 27 months. Current public services are for emergency care with limited focus on prevention and restorative work. The NHHRC is proposing a universally accessible scheme, *Denticare Australia*, comprising a mix of public and private service delivery, for preventive and restorative dental care and dentures regardless of consumers' ability to pay. This would be funded through an additional Medicare levy and support pre-school and school dental programs; and improved oral health promotions. The Association for the Promotion of Oral Health suggests dentistry is perceived as an ancillary health service rather than a core health service and is not well-integrated with general health services at all levels, resulting in decreased population health status.¹⁰

The NHHRC said governments contribute less than 20 per cent of all spending on health services while health insurers contribute about 14 per cent, with individuals self-funding 66 per cent of the total cost.

⁸ National Mental Health Consumers and Carers Forum. (2008). Submission 126 to the National Health and Hospitals Reform Commission.

⁹ Spence, J. and Harford, J. (2008). Improving oral health and dental care for Australians: Discussion paper commissioned by the National Health and Hospitals Reform Commission.

¹⁰ Association for the Promotion of Oral Health. (2008). Submission 421 to the National Health and Hospitals Reform Commission.

The NHHRC believes the separation of oral health from general health is incompatible with comprehensiveness, where a health and aged care system should be able to meet the entire range of people's health needs over their lifetime.

Chapter 12 focuses on strengthening the governance of health and health care. The NHHRC believes there is widespread dissatisfaction with the current fragmentation of services and holistic systemic dysfunction, often as a result of governance and the 'blame game'. It perceives that no one government has an understanding of, or exposure to, the health system as a whole. Also, the NHHRC feels consumers and their families have inadequate opportunities to participate in health system processes and separate funding streams distort priorities, causing problems in primary health care and other service delivery.

In the report, the NHHRC suggested three options for better governance, as:

- Continued shared responsibility between governments, with clearer accountability and more direct Commonwealth involvement
- Commonwealth solely responsible, with regional providers of some services
- Commonwealth solely responsible, with competing health plans responsible for providing cover for most services.

It should be noted that power should be aligned with responsibility and responsibility with capacity to pay. As far as possible, a government should be directly responsible and accountable for the effects of its funding decisions on services and fiscal and program management decisions should rest with government. The NHHRC identified a preliminary set of functions or responsibilities which would benefit national leadership, supporting:

- Health professionals in working towards a high quality and safe health system
- National registration of health professions
- A national clinical education and training agency
- A national health promotion and prevention agency
- A national health intervention assessment
- National regulation of private hospitals
- National support for innovation
- A national performance reporting and accountability framework
- A national Aboriginal and Torres Strait Islander Health Authority.

Chapter 13 looks at the raising and spending of money for health services identifying 9 per cent of gross domestic product (\$94 billion) is now spent on health services. Further, it is projected that health and aged care spending will increase to \$246 billion or 12.4 per cent of gross domestic product by 2032-33, with the commitment to caring for consumers with chronic disease a high contributing factor. Australian households are spending more directly on their health care, rather than through taxation or private health insurance with about 5.3 per cent of the weekly household budget paying for health services [2003-04]. Where health services sit outside universally accessible programs, consumers are experiencing high financial commitment and distress. The NHHRC believes a better system of safety nets is needed to support equitable access to necessary health services.

The NHHRC questions who should pay for health services or how the money should be raised. Any options have consequences for individual health consumers, their families and the nation. The NHHRC suggests the greater the level of taxation in a country, the less money households can spend on their individual choices between housing, travel, food and health care. Further, the NHHRC said

the balance between taxation and voluntary payments, either through health insurance or out-of-pocket expenses, is essentially a political choice. Consistent with their principle of public voice and community engagement, the NHHRC believes there needs to be strengthening of mechanisms to facilitate broad, informed public debate about the value of health, how much is spent on health care and what it is spent on.

In relation to the allocation of funding for health services, the NHHRC proposes three main methods of distribution, as:

- Capitation or pre-capita payments – under this model, a health service has a strong incentive to manage both the volume of services provided to each person and the cost per unit of service. This model may provide a strong incentive to undertake more prevention and early intervention to keep people healthy
- Activity-based payments – drive greater efficiency and productivity. These may include performance related payments related to outcomes or processes associated with clinical quality.
- Grants, block payments or salaries determined by public policies, history etc.

The NHHRC also believes capital costs should be incorporated in all recurrent funding arrangements. The Australian Institute of Health and Welfare reported 5.6 per cent (\$5.3 billion) of the total spending on health was invested in health facilities and equipment by the Commonwealth Government; state, territory and local governments; and the non-government or private sector.¹¹ The NHHRC argues that the cost of capital should be included in the price or funding payments made by all payers of health services. Further, it believes suggested reforms will have capital implications at least on a transitional basis.

Chapter 14 relates to a sustainable health workforce for the future. Currently 8.6 per cent of people (600,000 health staff and 275,000 support staff) are employed in the health sector while another 470,000 Australians act as informal carers outside the workforce. The NHHRC reports that Australia is not currently self-sufficient on a net basis across all categories of health professionals and with an ageing health workforce, the increase in chronic disease and the demands of an ageing population, greater pressure will be placed on an already over-burdened workforce and health system. The NHHRC proposes:

- Promoting better workplace culture and management and leadership skills at all levels of the system
- Implementing models that formally involve all health professionals in guiding the future directions of health reform
- Facilitating better access to care in remote and some rural areas, through nurse practitioner and other registered health professionals' services under the supervision of a medical practitioner, referrals to some diagnostic services and specialist medical services and approved prescription formularies
- Adopting a competency-based framework for and a multi-disciplinary approach to education and training of health professionals
- Establishing a national clinical education and training agency
- Implementing a comprehensive national strategy to recruit, retain and train Aboriginal and Torres Strait Islander health professionals at undergraduate and postgraduate levels.

¹¹ Australian Institute of Health and Welfare. (2008). Health expenditure Australia 2006-07. Canberra: Author.

Medicare data shows 36 per cent of doctors currently working in Australia were trained overseas with 41 per cent of rural and remote area doctors having trained overseas.¹² The NHHRC believes this is not sustainable or ethical, for the doctors' countries of origin and for these doctors, who are being located in alien environment, outside their cultural environment, without supports.

The NHHRC also raises concern about the role of informal carers. It cites a Productivity Commission report, stating informal caring is expected to rise by 160 per cent between 2001 and 2031, while the availability of informal carers will only increase by 60 per cent.¹³ This has major implications for unwell citizens, frail people and persons with a disability being able to live within their chosen community environment with adequate and appropriate supports in place.

To encourage more Australians to undertake a career in health, workloads and stress levels need to be addressed now; and ongoing professional development, comprehensive locum arrangements and peer mentoring programs must be set up Australia-wide. Allowing nurse practitioners to prescribe PBS subsidized medications and order diagnostic tests under the Medicare Benefits Schedule, will in some way, alleviate workforce concerns.

Chapter 15 focuses on fostering continuous learning in the health system. The NHHRC acknowledges that Australia has an excellent tradition and track record of achievement in health and medical research, but suggests health services research is under-resourced. Additionally, the NHHRC believes Australia has difficulty in transposing research findings into clinical practice in a timely manner. It feels the Commonwealth Government should increase the priority of health services research to achieve this end. Further, the NHHRC believes the National Health and Medical Research Council should consult widely with consumers, clinicians and health professionals to set priorities for collaborative research centres and supportive grants to integrate multidisciplinary research across care settings and have designated resources to disseminate findings. Further, it feels the National Institute of Clinical Studies could include a clearing house function to collate and disseminate innovation in the delivery of safe and high quality health care; and health services and health professionals share experiences through forums and other engagement mediums.

The NHHRC suggests a standard national curriculum for safety and quality be built into education and training programs for all registrable health professionals. Also, it believes an independent national safety and quality body be established and that all hospitals, primary health care centres and residential aged care facilities produce an annual report on their quality improvement and research activities. The NHHRC suggests sufficient resources are being applied to areas of health and medical research to promote health and wellbeing and to prevent ill-health; the delivery of more effective health care based on evidence-based practice; and the development of new therapies and cures.

¹² Australian Government Department of Health and Ageing. (2008). Report on the Audit of Health Workforce in Rural and Regional Australia. Canberra: Commonwealth of Australia.

¹³ Productivity Commission. (2008). Trends in aged care services: Some implications. On 1 March 2009, downloaded from: http://www.pc.gov.au/data/assets/pdf_file/0004/83380/aged-care-trends.pdf

The NHHRC has an extensive, online survey about the interim report. It covers each of the chapters in the report. Responses close on Monday, 16 March 2009. The survey can be accessed at:
http://www.surveymonkey.com/s.aspx?sm=fKQrHFTU_2btXyxHpaKDfcZQ_3d_3d

Note

Models of care need to be informed by the needs of local communities, and be responsive to the strengths and limitations of the environments in which people live. Health services should reflect local needs, address inequity, prioritise services to the most needy, and involve communities and individuals at all levels of planning and service provision. Services and technology to provide for better health outcomes should be affordable and acceptable to their communities.

Attachment

A Healthier Future for All Australians: Interim Report of the National Health and Hospitals Reform Commission: Summary.

This one-page document provides a comprehensive overview of the themes, key reform directions and principles outlined in the full interim report.

Health Consumers Queensland Secretariat
GPO Box 48
Brisbane QLD 4001
07.3234 0611
DSHCO@health.qld.gov.au
www.health.qld.gov.au/hcq
4 March 2009