Australian Health Services: too complex to navigate

A review of the national reviews of Australia's health service arrangements

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Australian Health Policy Collaboration
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THE AUSTRALIAN HEALTH POLICY COLLABORATION, VICTORIA UNIVERSITY

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About us

The Mitchell Institute's mission is to strengthen the relationship between evidence and policy, and, to improve equity of opportunity and success in both health and education. The Australian Health Policy Collaboration (AHPC) is a health policy think within the Mitchell Institute. We have built a collaborative approach with Australian health experts, academics, researchers and policymakers to translate the best evidence into effective policy development and implementation centred on the current and future impacts of chronic diseases in Australia.

About the Authors

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Foreword

I have had the privilege of engaging with and observing the world class aspects of Australia's health services for many years, but I've also seen first-hand the layers of complexity and inefficiency which can result in many Australians receiving inefficient and sometimes suboptimal care.

I have worked as a Health Minister in the Victorian Government, served as a Commissioner for Aged Care complaints; chaired the Australian and New Zealand food standards authority, participated as a commission member for a national review of health services that is cited in this report, and recently was proud to serve as a National Mental Health Commissioner.

Throughout my time of engagement in health service policy and administration, despite Australian governments maintaining a strong focus on health policy, the national appetite for structural reform has been limited. Government initiatives have generally focussed on immediate pressures facing health expenditure and public funding of health care; pressures on hospitals and the health workforce, and pressures arising from an ageing population, increasing chronic diseases affecting more of the population, and the rising costs of health treatments and technologies that manage those chronic diseases and prolong life. Rarely have commissioned health inquiries been asked to take a broad system perspective so that, despite a plethora of national inquiries and reviews, and many state and territory level initiatives, we find ourselves with health service arrangements that do not respond readily and effectively to the contemporary health and financing challenges facing them and the Australian population.

Historically health services have developed into systems arranged to provide the most appropriate services for traumatic injury, infectious diseases and single diseases. In the 21st century, health needs are radically different with the dominance of non-infectious chronic diseases in world populations requiring very different health services responses.

The expectation that contemporary health policy and services should be focussed on chronic disease prevention and management is not new. A considerable proportion of the national reviews cited in this report have been commissioned to consider the implications of the rising prevalence of chronic diseases. However, the complexity of our federated health arrangements – in policy, funding and service delivery – have meant that limited reviews have limited capacity to provide effective advice on how governments can best address rising health costs, the ageing of the population and the growing impact of preventable chronic diseases. Nonetheless, reviews have made similar comments and provided consistent advice on the structural challenges that need to be addressed if the problems the reviews have been commissioned to consider are to be effectively addressed. Overall, the consistent advice from the reviews that have been commissioned is that, without significant structural change, the costs of preventable illness and resulting healthcare demand will continue to be a blinding headache for governments and individuals alike.

This report, 'Australian health services: too complex to navigate. A review of the national reviews of Australia's health service arrangements.' highlights the complexity and dysfunction of the current system and aims to bring attention to the considerable agreement across national health reviews over the past 35 years.

The reviews considered here have been focussed on inquiry, none have been tasked with effecting change. A strong message emerging through this report, from the reviews considered, is that the

provision of efficient, accountable and sustainable health services for the nation would almost certainly be more achievable if a review body with the authority and capacity to influence the structural and funding arrangements for acute and primary health services was established.

Australia Speaks 2018, a report published by Research Australia last year, found that Australia's number one priority for government is improving hospitals and the health care system.

A national discussion about how to re-engineer current arrangements to provide systemically, effectively and efficiently for chronic health conditions, their prevention, treatment and management, is now a pressing issue. This report suggests that discussion needs to encompass health system stewardship, health care financing, organisation of the health workforce and health infrastructure, models of health care delivery and the provision of care, health care quality and safety and the dissemination of health information to consumers.

It is my hope and expectation that clinicians, researchers, policy professionals and consumer and health organisations will use this report and its findings to reignite a much-needed national discussion about what we need to do as a nation.

These reviews have provided a solid roadmap for improvement. We need governments and health leaders to get on with building a health system that is simpler, fairer and more affordable for all Australians. The roadmap for reform is already there, it's time to get on with it

The Hon Robert Knowles AO,

Chair, AHPC Advisory Board

Australian health services: too complex to navigate

Executive summary

The Australian health care system performs well by international standards in terms of health services and outcomes. However, it also struggles to provide equitable access to care for all Australians and often fails to prevent and manage chronic disease effectively.

Medicare is regarded as the backbone of Australia's health care and accessibility. The original intentions of Medicare[1] – a funding system for universal health care that is simple, fair and affordable – are largely agreed and valued. The scheme however, was superimposed on an existing set of health care services provided by the states, not-for-profit and private providers and private insurance policies held by about half the population. Over the last 45 years, there have been many amendments, workarounds, superimposed fixes and band aids applied to our health system from multiple sources with competing agendas.

The result is less an Australian health system than a complex set of services, with multiple providers and multiple payers generating complexity for both patients and providers alike.

The complexity of the system has further increased due to a rapid rise in the incidence of chronic diseases in the population, and rising demand for services. The Australian population is ageing and lifestyles have changed over time, making chronic disease our most dominant contemporary health issue. The demographics of the community are changing and Australia's geographical size and diversity remain challenging. Expenditure on health care is projected to rise faster than both national income and personal incomes.

Dramatic and continuing advances in medical knowledge and technologies combined with developments in many other areas, including information and communication technologies, have both enabled significant improvements and efficiencies in health care and at the same time led to increased expectations and use of services.

The health needs of the population in Australia in 2019 are very different from those in 1975 when Medibank, the first version of Medicare, was established. The pace of adaptation has been insufficient to offset rising community concerns about gaps in service, long waiting times, lack of access to the latest drugs or technologies, and rising health insurance premiums and co-payments. The calls for action have grown louder, budget pressures at both state and federal levels of government have increased; and there is competing (and related) pressure from the aged care and disability sectors. Part one of this report provides an overview of the growing complexity of funding and access to health care services,

Successive governments have sought advice on how to deal with the pressures on, and of, the health system. Multiple reviews and reports related to the health care system have been instigated by federal and state governments over the past 40 years.

Part two of this report examines a range of Australian government reviews into the health system. The reviews examined are the most prominent that focussed on the function and capability of Australia's health services, to provide universally available, affordable and appropriate health care services for

[1] at its inception in the 1970s as Medibank and its subsequent second version, as Medicare, in the early 1980s

all, with specific consideration of those that address chronic and complex conditions and diseases.

This report shows that national reviews consistently agreed on the same underlying challenges and that new models of health care delivery and financing were required to address these challenges. The reviews differed in the emphasis given to clinical and financial matters; they varied in their proposals for specific changes to the mix of finances. However, and most tellingly, the reviews considered in this report all highlighted the current complexity of arrangements as a major impediment to improving both the patient experience and health outcomes, and the efficiency of the system.

Successive reviews found that current funding arrangements create – or fail to address – barriers to coordinated, clinically effective and efficient health care; that is, health care that is of the required quality and clinical appropriateness and that is delivered in the most cost-effective setting, particularly for chronic disease. This was best illustrated by a quote from the Productivity Commission's 2017 review:

"Australia's messy suite of payments are largely accomplices of illness rather than wellness, only countered by the ingenuity and ethical beliefs of providers to swim against the current".

This myriad of reviews have been asked similar questions and provided consistent advice:

- Without structural change to the way in which health care is delivered and financed, the Australian health care system will continue to struggle to meet contemporary needs and expectations of its citizens.
- Until the current complexity of the system, particularly financing, is re-designed, patient journeys will be inefficient, less than effective and time-consuming. Health care providers will continue to need to create work-arounds to minimize structural inefficiencies and barriers. Patient costs will continue to escalate and health outcomes for some population groups will continue to be compromised.
- Without significant change in current funding arrangements and in service models, investment in prevention to improve health and reduce preventable disease will languish as the poor relative of high cost reactive healthcare services and investments.
- The role of primary care needs to be strengthened with priority given to better quality outcomes and outcome measurement. Funding models need to support prevention, management and support of chronic health conditions.

Reviews have agreed that the fundamental challenge facing Australian health care is how to meet and reduce the rising demand for care of chronic disease. The complexity of the Australian health care system provides significant challenges for reform. A recent OECD comparative review described the Australian health care system as 'too complex for patients'; and, this report shows that Australia's current health arrangements fall well short of the goals of Medicare.

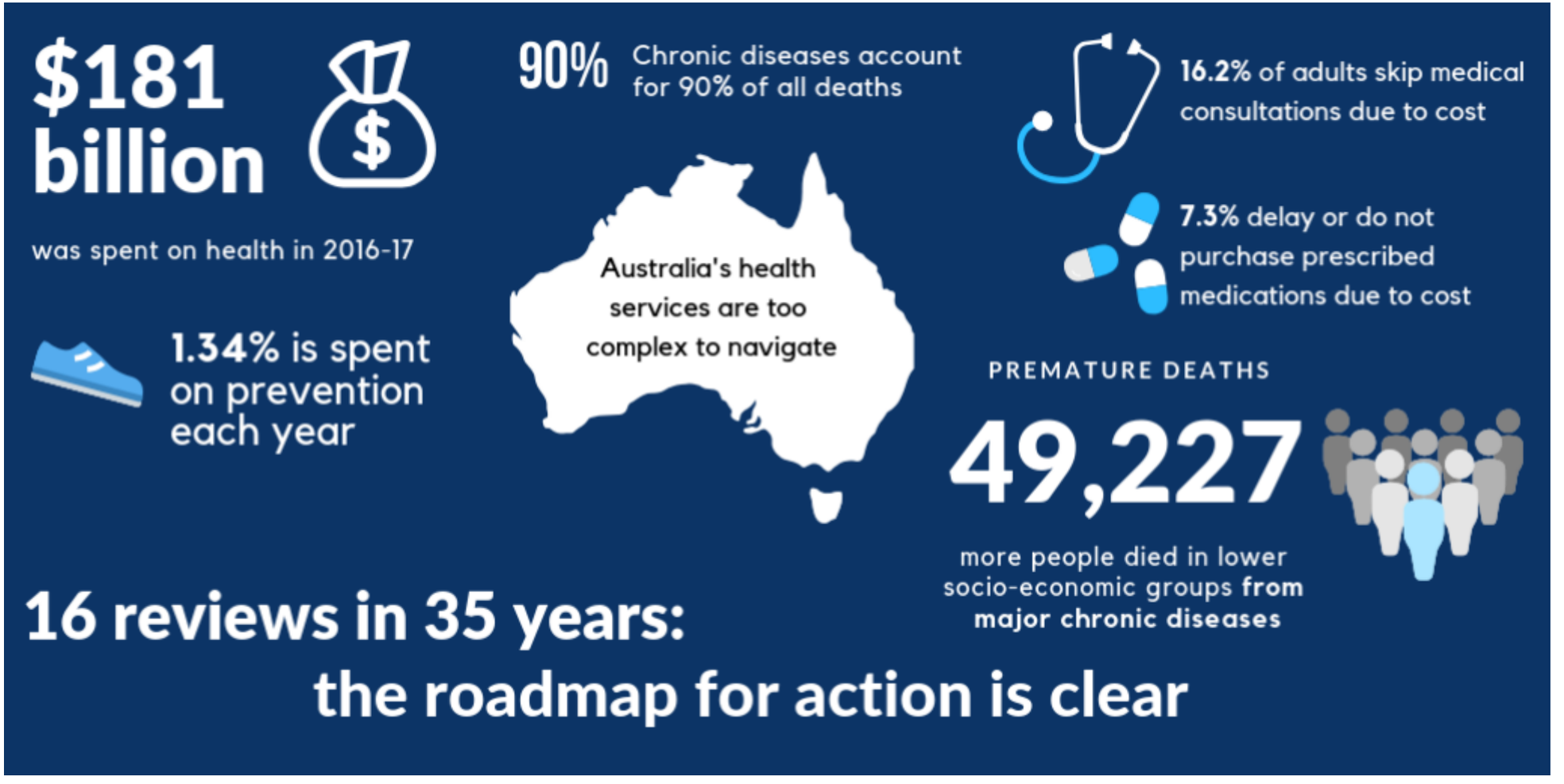
There is also a very high level of agreement on what needs to change. A first step towards meaningful reform is to re-cast the current policy debates to focus on areas of agreement, rather than disagreement.

Many reviews have recommended national stewardship arrangements to cut through the structural problems. Breaking down the current inefficient arrangements between states, the Australian government, private health insurers and individuals, would allow for new payment systems that

encourage clinically and cost-effective health services relevant to contemporary health needs.

Australia's health care system continues to be too complex to navigate for governments and funders, and for consumers and providers alike. We have decades of consistent, unambiguous advice on what needs to be done and there are strong international models and examples of how to do what needs to be done.

Australia needs governments and health leaders to take the advice that is in place and get on with building a health system that is simpler, fairer and more affordable for all Australians.


$181 billion
was spent on health in 2016-17
1.34% is spent on prevention each year
90% Chronic diseases account for 90% of all deaths
Australia's health services are too complex to navigate
16.2% of adults skip medical consultations due to cost
7.3% delay or do not purchase prescribed medications due to cost
PREMATURE DEATHS
49,227
more people died in lower socio-economic groups from major chronic diseases
16 reviews in 35 years:
the roadmap for action is clear

Introduction

In 1975, Australia moved to establish a national universal system of health care access now known as Medicare. The policy aims were to ensure that all Australians, irrespective of where they lived, or their personal financial circumstances, would have timely access to safe and affordable health care. The system's architects believed that the mix of general taxation and a specific Medicare levy would fund the system in a fair and equitable way, and that the establishment of the national system would make the resulting services simpler to navigate and administratively cheaper than the more complex arrangements they replaced.

Despite the intentions underpinning the design principles of Medicare, forty years on, that national system is under stress. A changed pattern of illness, an ageing population and the emergence of new medical technologies have driven an increase in demand for and cost of services at a time when the demand for other government services has also grown. The health budgets at both national and state levels are under significant pressure and out of pocket expenses for users of health care services are rising.

Four trends stand out:

- first, life expectancy for most Australians continues to improve, but has been accompanied by a rise in chronic disease; we are living longer but with more chronic illness or disability.
- second, the development of medical knowledge and growing sophistication of medical technologies means that treatment options continue to grow exponentially.
- third, health expenditure is rising more quickly than Gross Domestic Product (GDP) and the Consumer Price Index (CPI). Some current forecasts suggest health costs will equal, or surpass, our current national tax take within the next few decades.
- fourth, there are emerging gaps in services and health outcomes because of an inequitable distribution of, and access to, health resources. In so many ways it appears that the very ideals of the Medibank/Medicare system are under threat.

Successive national governments have commissioned multiple reviews of the health system or its parts through recent decades. Arguably the best health policy minds in Australia have undertaken these reviews. Many have included practitioners, and incorporated the perspectives of the many professions within the sector, together with other key suppliers and financiers to the sector. Some have been undertaken by economists from outside the sector. Many reviews included wide-scale consultations to understand both the systems' strengths and its vulnerabilities. They drew on international experience and sought to tailor those lessons to the Australian experience. They built on the fundamental building block that is the national commitment to a universal health care system.

Many of these reviews made it clear: business as usual is not an option. But despite a core of common findings and recommendations, many recommendations have not been implemented, with reforms to strengthen the system incremental and often lacking bi-partisan support. Indeed, the current political discourse about the health system is artificially divisive and misleading, with debate focused on the differences rather than the areas of agreement, the vulnerabilities of the current system, or historical and ideological barriers to reform, rather than evidence-based system improvements.

In this paper, we analyse these reviews and show the extent of shared agreement regarding the challenges – and considered solutions. To begin, we describe the starting point – the introduction of a universal health care system, founded on the core principles of equitable and timely access, universal insurance and the efficiency and simplicity that comes from a single system. In section 2, the report shows the current challenges to that system.

In section 3, the report summarises the general policy directions that have been recommended as a response to those challenges, highlighting the considerable agreement across reviews and any differences in review approach. We note that these recommendations are largely in line with international thinking and experience, although we also note that other countries are ahead and working through or refining their policies and implementation of these directions.

In sections 4 and 5, we seek to capture first what has been implemented, where there have been policy gaps or reversals and current plans for improvement, and second, the impact of these changes.

Appendix 1 provides a list of the reviews analysed, Appendix 2 details the review recommendations and associated government responses and Appendix 3 provides a summary of the review recommendations grouped by health system component.

The report reveals the strength of agreement between the reviews, and that explicit non-partisan commitment to the principles of universal access to health care and to multi-lateral collaborative stewardship of health services and health funding arrangements is of fundamental importance. Without this commitment and collaboration, the ideal of appropriate and adequate, affordable and sustainable contemporary health services is unlikely to be achieved. The reviews recognise that, as in any sector, the capacity to provide longer term policy stability in operating environments is crucial to both capital and skills investment.

And finally, the report concludes by suggesting that the systemic challenges to the Australian health care system need to be fairly presented and represented in public debates. While policy and health sector insiders may understand, and accept, the challenges and general directions for change, the lack of an informed and genuine public debate means that the general community does not yet necessarily accept them nor understand them as systemic issues. They do indeed see, or experience them, as longer waiting times, higher out-of-pocket expenses or clunky services which do not connect, requiring repetitive information and/or tests. They also see reports of adverse events, such as hospitals with high post-surgery complication rates or instances of incorrect medications being administered, that appear as systemic failures. But political and media responses commonly emphasize that additional resources, especially for hospitals, will fix the problem; alternative proven models of care are not presented or supported.

The reviews are consistent in their findings that if we are to maintain the Australian ideal of universally available and affordable health care services for all, we need new ways of financing and delivering high quality contemporary care to more people with chronic and complex conditions and diseases. They are also clear that without structural and governance changes that allow greater clarity about roles and responsibilities, and the emergence of a body that can lead change over the long term, insufficient progress will be made.

To achieve the improvements called for by these reviews requires a genuine national bi-partisan, and long-term approach to health care system improvement, focused on the evolution of health care systems and capabilities to cope with contemporary patterns of illness and health care needs.

Part one: the growing complexity of the system

1. The starting point – Medibank 1975

Concerned about the 17% of Australians without private health insurance, and who therefore did not have access to basic health care, in 1975 Australia established a national system of publicly funded health to enable universal access to health care. The scheme aimed to ensure people had timely access to adequate, safe and affordable health care when and as they needed it, irrespective of where they lived or their personal financial circumstances. Those designing the new system were charged with ensuring that it was universal, fair, affordable, and simple[1]. The then Health Minister, the Hon. Neil Blewett, emphasized the system was 'desirable from an equity point of view' and 'in terms of efficiency and reduced administrative costs'.

1.1 An insurance scheme

Medibank was designed as an *insurance* scheme, with the insurer (the Australian government) paying for, or reimbursing the costs of, designated health care services and treatments. It encompassed the health care services historically provided through the states' public hospital systems; the private practices of doctors, specialists and other health professionals, and the privately-owned pharmacies[1]. The scheme comprised, or incorporated, three main components:

- hospital cover: free treatment for public patients in public hospitals;
- Medicare Benefits Scheme (MBS): payment of benefits or rebates for professional health services listed on the MBS[2]; and
- Pharmaceutical Benefits Scheme: subsidisation of a wide range of listed prescription medicines.

Medicare is not the only health insurance pool in the Australian health care system. Just as the scheme did not change the arrangements for the provision of health care services, so too did it leave in place the existing private health insurance that a proportion of Australians already had, and continue to have. Indeed, over the decades since, tax incentives have been provided to encourage the take-up of additional health insurance, which contributes to the cost of treatment in private hospitals or as a private patient in public hospitals. The extent of these incentives has varied over time.

The most recent data shows that for the first time in 15 years, the proportion of the population with private health insurance is declining and, those who do retain it are opting for reduced cover, as the perceived value of private insurance declines. In June 2018, 45.1% of population had private insurance hospital treatment cover and 54.3% of the population held some form of general treatment cover, down from 47% and 56% respectively in 2015[2].

1.2 Jurisdictional roles and the funding of Medibank

The establishment of Medibank and subsequently Medicare brought the Commonwealth firmly into a dominant health policy, funding and service provision position through the agreement with states and territories to provide free health care for all Australians in public hospitals, together with free or subsidized primary and specialist health care through fee for service arrangements. Subsequently,

[2] There are two distinct schemes in operation; the original Medicare Safety Net which was introduced at the same time as Medicare in 1984, and the Extended Medicare Safety Net which was introduced in 2004 and provides an additional rebate for Australian families and singles who incur out-of-pocket costs for Medicare eligible non-hospital services.

the Commonwealth government focus has been on responsibilities in aged care, in specific areas such as population health and mental health and on health workforce. These interventions have often intersected with long-standing responsibilities of state and territory governments and have not always improved the efficiency and effectiveness of health care arrangements. At no time has there been a clean system design; adaptation and supplementation have been the key system design means.

Funding for Medibank (known as Medicare from 1984), was derived originally from Commonwealth general revenue. This was subsequently complemented by a Medicare Levy to ensure that people with the capacity to do so should contribute to the cost of the provision of health care. The Medicare Levy has risen to its current level of 2% on taxable income[3]. Many in the community now believe this levy is a hypothecated tax and that it funds health care services in entirety. However, the levy is not hypothecated and it has been calculated to contribute less than 15% of the cost of Medicare health service subsidies (MBS, PBS and Commonwealth hospital funding) and less than 10% of total health care expenditure when state and territory government contributions to public hospital treatment are included[3].

1.3 A national planning commission

Importantly, however, in parallel with the implementation of Medibank was the establishment of the Hospitals and Health Services Commission. From 1972 to 1978, the Commission led Commonwealth involvement in health services delivery, developing policies for the supply and distribution of health services. The Commission established the first national health service planning model, which envisaged a network of services comprised of primary care, private specialist care, hospitals, nursing homes, hostels and rehabilitation and domiciliary care. Even as the investment in increasingly sophisticated acute facilities began through this period, the Commission recognised the central importance of primary health care. This Commission developed a long-term blueprint for the Australian health care system. The independent national health planning commission established as part of the original plan for a national health care system was abolished in 1978. It has not been replaced.

1.4 Summary

- Medibank/Medicare is effectively a publicly financed insurance scheme that sits over the top of historically evolved health care institutions, drawing these into one loosely coupled 'system' to provide universal access to basic primary and acute health care.
- Consequently, the current Australian health care system has multiple payers/funders (federal and state governments; private health insurers and individuals) together with multiple care providers across the private and public sectors.
- There is duplication of cover for those who also hold private health insurance and the existence of rebates and tax subsidies for private health insurance exacerbates this.
- Because Medibank/Medicare was overlaid on what was there previously, the complex arrangements for delivery and financing, split between different levels of government and the private and public sectors remained in place. The scene was set for incremental, or evolutionary, adjustment to the existing infrastructure, rather than structural transformation.

2. The major forces shaping the demand and supply of health care

Like every other sector, the health care sector is subject to the major demographic, technology and economic changes of our time. These forces shape the nature of demand and, together with the regulatory and policy environment, the supply of health care services. These forces have already led to change within the sector over time, and can be expected to continue to drive, and enable, future change. This section describes the key drivers of those changes and their consequences.

2.1 Epidemiological and demographic transitions

Changed patterns of disease have increased demand for services and require different kinds of services, skills and infrastructure

The health care needs of contemporary Australians have changed since 1975.

Life expectancy has increased dramatically for most Australians[4]. A girl born between 2011 and 2013 can expect to live to 84.3 years, and a boy would be expected to live 80.1 years, compared to 79.2 and 72.7 years for those born in 1984[5]. Improved living conditions, better nutrition and preventive health programs, such as mass immunisation, together with advances in medical knowledge, treatments, practice and technology, have all contributed to significant increases in life expectancy. However, these improvements have not been equally experienced by all Australians. For the Aboriginal and Torres Strait Islander population born in 2010–2012, life expectancy was estimated to be 10.6 years lower than that of the non-Indigenous population for males (69.1 years compared with 79.7) and 9.5 years for females (73.7 compared with 83)[5].

Furthermore, by 2011, chronic diseases had become the leading cause of illness, disability and death in Australia, accounting for 90% of all deaths[6]. Half of all Australians live with at least one chronic disease, and almost one in four (23%) live with two or more[4]. The AIHW has estimated that 4.5 million years were lost to premature death or living with chronic illness during 2011[6]. With rates of chronic disease rising between 2011 and 2018[4, 6], it's reasonable to expect the estimate of 'years lost' to have further increased.

The rise in prevalence of chronic disease in Australia is mirrored in developments internationally. For the past 20 years, new models of care appropriate to chronic, as opposed to acute, conditions have been trialled and adopted in many countries. These models of care are characterised by typically being in the primary care or community care sector, delivered by a multidisciplinary "team" with a focus on more integrated, coordinated oversight among and between the community, primary and tertiary care sectors. These too have been introduced in Australia, with more policy focus on the strengthening of the primary care sector sitting alongside the development of new acute beds in public hospitals.

This has meant the need to develop new skills and roles within the health sector. Despite the continued popularity of, and demand for, specialist services, the new models of care require more general practitioners and additional skills sets within GP practice.

Similarly, Information and Communication Technology (ICT) is increasingly being embedded into health care provision – such as electronic health records; electronic transfer of medical information between the multiple care providers a chronically ill patient typically sees – to underpin and efficiently manage the new integrated models of care demanded by chronic conditions.

More importantly, roughly one-third of chronic disease affecting the population is considered preventable. As a result, internationally and in Australia, there has been growing focus on new forms of disease prevention and maintenance of health. Alongside concern to reduce the incidence of risk factors, such as smoking, obesity, lack of physical activity and dangerous alcohol consumption, is an acceptance that health status is determined, or at least influenced by, other social characteristics (such as education, employment status, ethnicity and location) and the environment in which people live[7]. This includes acknowledging opportunities for prevention at different stages of the disease continuum, consisting of:

- Primordial prevention which refers to preventing the emergence of predisposing social and environmental conditions that can lead to causation of disease. It can also include population-based interventions to prevent the development of risk factors that lead to chronic diseases.
- Primary prevention which refers to limiting the incidence (development of new cases) of chronic diseases through eliminating or reducing specific risk factors and other determinants, while promoting factors that are protective of health.
- Secondary prevention, this involves reducing the progression of chronic diseases through early detection (usually by screening at an asymptomatic stage) and early intervention.
- Tertiary prevention, this involves improving function and minimising the impact of established disease. It also includes preventing or delaying complications through effective management and rehabilitation[8].

Despite the increasing prevalence of chronic disease and associated risk factors, the proportion of Australia's total health expenditure dedicated to prevention is less than 2%, much less than in New Zealand (6.4%), Canada (6.2%), the UK (5.4%) and even the USA (2.8%)[9, 10].

The rise of chronic disease prevalence in the population has resulted in an increase in demand for services, including diagnostic information and the emergence of new models of care as health professionals seek more effective and efficient management of chronic disease, including greater attention to prevention, early detection and management. To be both efficient and effective, these new models of care need to be more distributed, better connected and encompass:

- improved infrastructure;
- development of workforce skills and roles;
- strengthened primary care capacity: and
- greater investment in sub-acute facilities.

The systematic use of ICT is also essential to:

- improve the timeliness, use and quality of patient information;
- lessen the impacts of waste through duplication, gaps and errors in information that persist;
- and at least partly offset the disadvantage of geography and distance in access to services.

The ageing of the population exacerbates the growth of chronic disease and reduces the national tax base

Changing diseasepatterns are exacerbated by demographic changes. The ageing of the population itself is a driver of more chronic disease– 40% of Australians aged over 45 years have two or more chronic diseases[4].

Importantly however, the ageing of the population means a lower tax base from which to fund a growing demand for health care services. In 1975 there were 7.3 people of workforce age for every person over 65 years; in 2015 the Commonwealth government Intergenerational Report predicted that, by 2055, there would only be 2.7 taxpayers per 1 person over 65 years[11.] Many groups and government bodies, including the Australian Institute of Health and Welfare (AIHW) and the Productivity Commission, have argued that policy changes are needed so that long-term financing solutions can be put in place to meet the changing health care needs of Australians [5, 12, 13].

2.2 Advances in medical knowledge and medical technologies; impact of ICT

Advances in technology in all spheres of science and engineering (from ICT, materials science, nanotechnology to optimisation, robotics and 3D design) sit alongside, and have enabled, quantum advances in medical knowledge, medical technologies and drugs. Together they have led to significant new treatment options and these developments can be expected to continue. Increasingly effective in combating life-threatening diseases, these options herald personalised medicine and remote treatment.

However, these developments come at high cost, with significant research effort and long and expensive development processes required. The new drugs and technologies are sophisticated and expensive, but becoming (and expected to be) more readily available. Analysis of the drivers of the increase in health care expenditure show that the price of treatment has increased significantly, alongside greater demand and use of services.

Total Pharmaceutical Benefits Scheme (PBS) government expenditure rose from $10.8 billion in 2015-16 to $12.1 billion in 2016-2017, an increase of 11.3%[14] This was despite a 4% decrease in the amount of total prescriptions subsidised, indicating that increased expenditure can be attributed to a higher volume of more expensive pharmaceuticals being available and prescribed. The use of more sophisticated diagnostic imaging services covered under Medicare, such as MRI, CT and PET, has also risen significantly, including an annual increase every year since 2004-05[15]. This ongoing rise in the number of services, coupled with the introduction of more sophisticated and expensive imaging techniques, has resulted in the total expenditure of Medicare subsidised diagnostic imaging services increasing from $566 million in 2004-05 to over $3.3 billion in 2016-17[15].

However, these new technologies and expertise are not evenly distributed. Allocated through the public system by state governments and the private system through the market, geography and financial circumstances limit the availability of these advances. While these circumstances do not dampen high public expectations, they do lead to different rates of survival for some common chronic conditions and have led to some concern that rapid technological advancement may exacerbate inequitable access if, for example, government decides not to fund a service that is available privately, such as bariatric surgery[16].

The advances in medical and other technologies mean that:

- The electronic and digital collection, analysis and treatment of conditions is enabling more cost-effective, safer and more accurate treatment options and, slowly, enabling some of the tyrannies of distance to be lessened.
- Treatment options have grown, and will continue to grow exponentially, over future decades. Both the price and volume of these have risen in the past decade and are responsible for contributing to increasing health care expenditure.
- Expectations are high that they will be available to all, but rationing and clustering of resources means they are not.

2.3 Health care expenditure is rising more quickly than Gross Domestic Product (GDP) and Consumer Price Index (CPI).

The combination of more sophisticated and expensive technologies, and the growing disease burden among Australians, is driving up both the use and costs of health care services. Some current forecasts suggest health costs will equal, or surpass, our current national tax revenue within the next few decades[11].

At 10.3% of GDP, Australia's 2017 health care expenditure (from all sources) is above the average for OECD countries and has continued to rise while that of other countries has stabilised or even fallen[17]. Partly this reflects the general trend noted internationally that expenditure on health care will rise as GDP rises – and will fall as GDP falls. Thus, some of the continued rise in Australian expenditure is a function of our relative success in weathering the global economic downturn from 2007, in contrast to other nations that have seen their expenditure stabilise. However, health care expenditure is rising more rapidly than CPI, indicating that the true costs of health service delivery is undoubtedly increasing, irrespective of the GDP trend[17].

But, as noted above, there are concerns about the capacity for Australia to continue to finance the desired level of health care through its current pattern of taxation, private insurance and user payments. For example, the 2015 Intergenerational Report forecast that, without policy change, Australian Government real health expenditure would more than double over the next 40 years[11] At a time when the national tax base is expected to shrink, without anticipatory policy change, these projected health expenditure increases, together with the many competing demands for resources such as those for national security, education and social care, are expected to drive long term structural budget deficits, leading to higher out-of-pocket costs and longer waiting times for consumers.

Although the Australian government Intergenerational Reports highlighted the strain of health care demand on the federal budget, it is in the budgets of state governments that stress is already evident. In 2016-17, health took up 16% of Australian government recurrent expenditure[18], compared to 26.9% in the states. The 10 year (2006-07 to 2016-17) average annual growth rate in health expenditure is also higher for states and territories (7.4%) than for the Australian government (6.5%)[17]. From 2015-16 to 2016-17, state and territory government contributions fell from 52.4% to 51.0%, with the Australian Government share increasing from 39.3% to 40.6%[17]. Health expenditure at all levels of government is expected to continue to grow, reflecting a higher demand for health services[18].

2.4 Summary

- The major demographic, economic and technological forces that affect other sectors are also shaping the demand and supply of services in the health care sector. An ageing population, increased life expectancy and the rise of chronic disease has led to increased demand for services; new ICT technologies enable a safer and more distributed infrastructure and set of services while new medical knowledge and technologies continue to provide new treatment options. At the same time, however these advances continue to raise expectations and demand, and the costs of treatment.
- Health care expenditure typically rises with national wealth. But the rate of growth in health care expenditure is faster than CPI and GDP, raising concerns about whether the current financial arrangements are sustainable in the light of expected continued growth in demand for services and ever–more sophisticated technologies.
- Together these forces have driven various governments to seek advice on how to adapt and change the health care system and its financing to create long-term sustainability. Although the immediate prompt to each government-initiated inquiry or review has differed, the significant driver of the perceived need for change in the Australian health care system has been the limitations of the funding and service models that were designed in the 1970s and 1980s. Forty years ago, political and public concern was principally focused on ensuring universal access to acute (hospital) treatment.
- Today's key challenge is chronic disease prevention, diagnosis and management, which is largely dependent on comprehensive and coordinated primary care that is ongoing, rather than episodic, and that requires additional and often different infrastructure, services and skills from those that have been in place for decades.

In the following section, we consider the major reviews, reports and enquiries commissioned by Australian governments or undertaken by national agencies through recent decades. The findings and recommendations from these reviews, reports and enquiries represent the major advice received by successive governments regarding issues and challenges for health care financing, service arrangements, service design and other components of Australia's health system.

Part two: a review of national reviews

3. Successive governments, successive reviews

Successive national governments, over several decades, have established substantial national reviews into the health care system, or parts of it. State-based reviews or plans have also been undertaken, with some taking a similar focus to those of national reviews or reports.

All reviews have acknowledged, explicitly or implicitly, the national commitment to a simple, fair, affordable and universal health care system.

Although most reviews have been established with acknowledgement of the context of an ageing population, a changing pattern of disease and rising health care expenditures, none have been charged with a systemic review of health care provision and services. Instead they have mostly been driven by, and focused upon, specific concerns, particularly: the projections of health care expenditure revealed by the Australian government Intergenerational Reports; community concern about, and media focus on, waiting times for elective surgery; reports of impending workforce shortages; concerns about maldistribution of workforce and facilities; variations in health outcomes and service usage; concerns about quality and safety, or rising out-of-pocket costs, private health insurance coverage and/or premium rises.

These concerns are neither unexpected nor unique to Australia. They have been developing over the past 30 years and are consistent with changing population trends and health needs in peer nations. And in that time, there has been a considerable body of knowledge built up internationally about new ways of both delivering and financing health care for chronic disease. This includes greater focus on the 30% of disease considered to be preventable and on early detection and management of chronic conditions both to improve the quality of life of patients and to lower the financial and resource costs of more severe untreated conditions.

The wide array of concerns evident across Australia's health system has meant that the scope of the reviews has been restricted to clusters of issues without necessarily a regard to the interplay of these issues and the reflection of that in services and access, nor to the overall performance of the complex funding and service arrangements in place.

3.1 WHO Health System Performance Framework and the Australian context

Australia's considerable investment in reviews and inquiries has taken a consistent specific-issue approach, contrasting with that proposed by the World Health Organisation (WHO). In 2001, the WHO recommended that assessments of the comparative performance of health care systems be undertaken against a framework of discrete and interrelated building blocks of national health care systems.[3] These were seen to be the principal building blocks of a health care system, together with the key processes and outcomes of those systems, as shown in Figure 1.

[3] In 2001 the World Health Organisation (WHO) released a framework to assess the performance of national health systems. This framework allows for assessment to be undertaken in two parts: first by considering the relative standing, or performance, of the building blocks of the system, and second, by considering the outcomes being achieved.

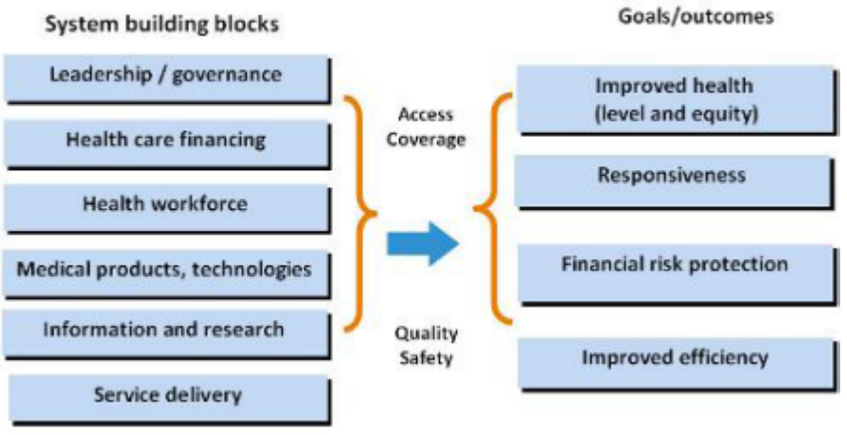


Figure 1: WHO Framework for Assessment of Health Care System Performance

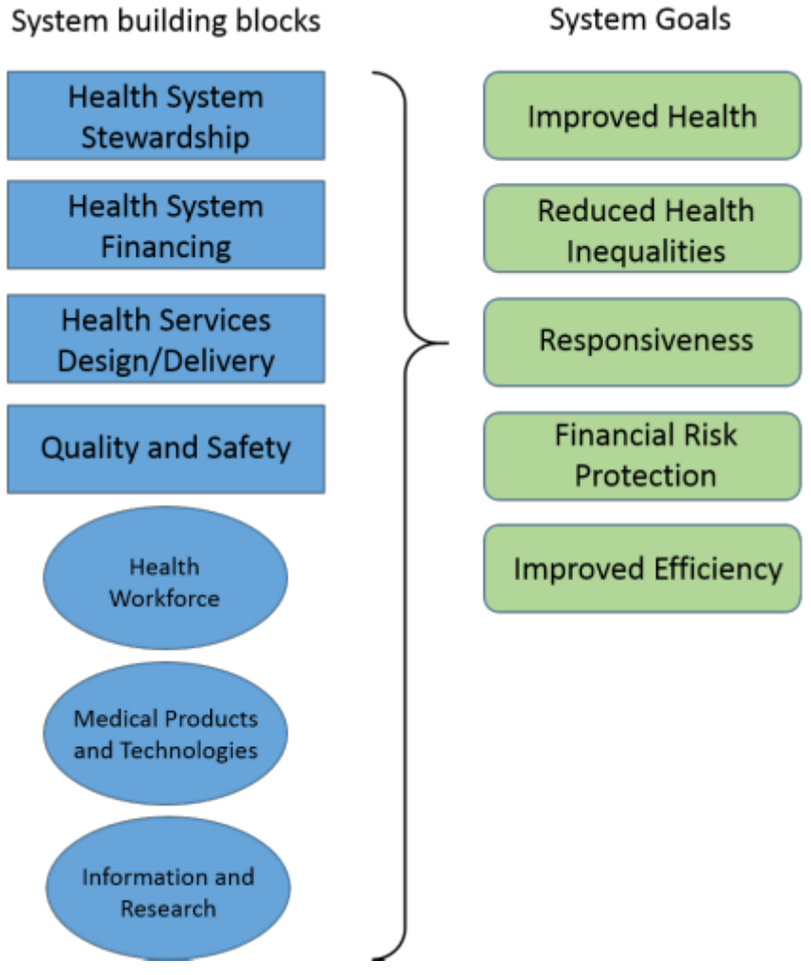


Figure 2: Adapted WHO Framework for Assessment of Australian Health System Performance

Recognising the limited scientific evidence-base to inform critical decisions on the organisation of health services and systems, the WHO Health Systems Performance Assessment Framework was developed to strengthen the foundations for evidence-based policies aimed at health systems development. After an extensive international consultation and analysis of health care systems, it established a common conceptual framework for health systems performance assessment and encouraged the development of tools to measure its components. WHO also sought to engender collaboration between countries in applying these tools to measure and then to improve health systems performance.

Because the WHO Framework provides tools with which to consider and improve the development of national health system performance frameworks and accountability measures, it is used in this report as a reference point to illustrate how the findings and recommendations from the selected Australian reviews align with the WHO *System Building Blocks*. We have slightly adapted the framework by ordering the *System Building Blocks* into two tiers, partly in line with the dominant focus of the selected reviews and partly to reflect the most significant barriers in an Australian context. Tier one building blocks proposed in this report are: health system stewardship (leadership and governance), health system financing, service delivery and design and quality and safety. The latter is in addition to the WHO building blocks, as it is a strong focus of Australian health policy and features in the reviews that this report analyses. Tier two building blocks, or 'enablers', are: health workforce, medical products and technologies and information and research. In Section 5, the report considers the review recommendations and reforms that have been implemented against the WHO framework system components. Appendix 2 (detailed) and Appendix 3 provide summaries of the review recommendations grouped by WHO system component.

3.2 The reviews and reports

This paper considers 16 national reviews or reports and one private health insurance consultation that have been commissioned subsequent to the establishment of the Hospitals and Health Commission in 1973.

Australia's federated governance, and the impact this has on the complexity and capability of health service provision, has been partially considered in many of the reviews, and a national audit has considered efficiency and productivity improvements across Commonwealth health expenditure. None have been charged with review of the overall performance of Australia's health system arrangements for effectiveness and efficiency against contemporary standards.

Whilst not including all national review-type initiatives, those that are considered in this report comprise the most prominent that have focused on the structural components – or building blocks – that are integral to the overall function and capability of Australia's health services. This report has given specific consideration to those that address the capability of health services to provide universally accessible, high quality contemporary care to people with chronic and complex conditions and diseases.

In summary, the various reviews have provided recommendations or policy proposals that align with the four broad 'tier one' system building blocks, adapted for use in this report from the WHO Health Systems Performance Assessment Framework. These comprise:

- health system stewardship;
- health care financing;
- health services design/ delivery; and
- safety and quality.

Additionally, specific reviews have considered what this report terms the 'enabling' (tier two) building blocks – health workforce; medical products and technologies, and information and research. Review recommendations have also regularly called for further examination of the 'whole' Australian health care system or further ongoing reviews to be undertaken.

The focus of each review is outlined in the following table, beginning with the most recent reviews.

Review Title	Review Summary
Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017)	Australia's fragmented funding and governance systems for health care — which largely reflects Australia's federal system and its hybrid private-public nature — work against achieving the best outcomes for a given overall expenditure. There is a need to create better structures and new incentives that promote efficient prevention and chronic illness management throughout the health system.
Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Productivity Commission Preliminary Findings Report Preliminary Findings (2016)	Government stewardship is critical to ensure health services meet standards of quality, suitability, and accessibility, giving people the support needed to make choices, ensuring that appropriate consumer safeguards are in place, and encouraging adoption of ongoing improvements to service provision.
Medicare Benefits Schedule (MBS) Review (2015-ongoing)	To ensure affordable and universal access to best practice health services and value for both the individual patient and the health system.
Private Health Insurance Consultations (2015-2016)	To consider how to encourage increased efficiency of private health insurance, enhanced value of private health insurance to consumers, increased effectiveness of Government incentives and improved financial sustainability of the private health sector.

Review Title	Review Summary
Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015)	Due to governance arrangements, primary care operates as a disparate set of services rather than an integrated service system and cannot respond effectively to changing pressures (demographic, burden of disease, emerging technologies, changing clinical practice) or coordinate care within and across various elements of the broader health system.
Efficiency in Health, Commission Research Paper, Productivity Commission (2015)	The health care system's institutional and funding structures compromise its performance, meaning that larger-scale reforms may be required to make real and enduring inroads into allocative and dynamic efficiency. There is need for a comprehensive and independent review to examine: private health insurance; investment in preventive health; financial incentives, including ongoing investigation of reform options to expand the evidence base, including trials, consultation and evaluation; and, current regulatory arrangements.
2015 Intergenerational Report – Australia in 2055, The Commonwealth of Australia, Department of Treasury (2015)	To assess the long-term sustainability of current Government policies and how changes to Australia's population size and age profile may impact economic growth, workforce and public finances over the following 40 years.
Contributing lives, thriving communities, National Mental Health Commission, (2014)	No level of government 'owns' mental health, which in turn has made it difficult to ensure accountability for mental health outcomes. Services are poorly integrated, overseen by different parts of government and based on widely different organising principles that are not working towards a common goal. Cross-portfolio interactions are particularly complex. For example, disability, income support and employment services are all Commonwealth responsibilities and yet states incur costs if people need care in public hospitals, interact with the justice system, or become homeless.
Reform of Federation, Issues Paper 3, Health (2014)	The complex split of government roles means no single level of government has all the policy levers needed to ensure a cohesive system. This affects patients with chronic and complex conditions - who move from one health service to another - and creates a challenge of providing better integrated and coordinated care.

Review Title	Review Summary
Review of Medicare Locals, (2014)	To determine if Medicare Locals were achieving the goal of becoming effective coordinators of primary health care development and service delivery, with a specific attention on performance metrics, governance arrangements, the role of general practice in primary care, the relationship between administrative and clinical functions, regional integration, market failure and tendering or contracting arrangements.
National Commission of Audit – Towards Responsible Government (2013)	The complex arrangements between Commonwealth and states and territories for public hospitals result in a lack of clarity when it comes to political responsibility and accountability. This creates an ineffective duplication of service delivery, an absence of proper program evaluation on Commonwealth programs, a lack of subsidiarity and both horizontal and vertical fiscal imbalance.
Building a 21st Century Primary Health Care System, Department of Health and Ageing (2010)	To provide the platform on which to build an effective and efficient primary health care system and provide a roadmap to guide current and future policy, planning and practice in the Australian primary health care sector.
Australia: The Healthiest Country By 2020, National Preventative Health Taskforce (2009)	To develop a strategy (focusing initially on obesity, tobacco and excessive consumption of alcohol) of primary prevention in both health and non-health sectors to prevent Australians dying prematurely.
Healthier Future for All Australians, National Health and Hospital Reform Commission (2009)	There is a lack of clarity of accountability and definition of responsibilities which creates the environment for a blame game, as each government can blame the other for shortcomings attributed to each other's programs. Although stewardship reform is not a 'magic bullet' solution for health care system problems, some problems can only be improved by reforming governance arrangements.
Intergenerational Report 2002-03, The Commonwealth of Australia, Department of Treasury (2002)	To assess the long-term sustainability of current Government policies and how changes to Australia's population size and age profile may impact economic growth, workforce and public finances over the 40 years.

Review Title	Review Summary
Private Health Insurance, Industry Commission (1997)	As it is impossible to define the most appropriate role for private health insurance without determining how the bigger system is intended to function, recommended a broad public inquiry into Australia's health system, encompassing; health financing, including state/federal cost shifting incentives; integrated health systems and coordinated car; the role of co-payments; competitive neutrality between players in the system; market power exerted by players in the medical system.
Looking Forward to Better Health, Better Health Commission (1987)	There is no national focus on illness prevention, no national directions, strategies, objectives or goals. Medical schools are failing to train students to promote health, research into illness prevention is fragmented and sparse, national funding for illness prevention is small and erratic and information and skills sharing is limited.

Table 1: List of reviewed reviews

The primary focus of the Terms of Reference of the reviews and reports, their main findings and advice are summarised in the following section. A detailed summary of the reviews considered in this report is at Appendix 1.

3.3 Reviewing health issues: focus areas, limitations and coverage

Although the specific mandates, durations of reviews and composition of review groups have differed, there is a striking similarity between most reviews of Australia's health arrangements, in both the findings of reviews about the key challenges facing health care for Australia and in their recommendations about the kinds of responses to these that should be made.

Most reviews have been asked to consider and recommend on:

- structural and governance arrangements for (parts of) the health sector, either locally[19] or nationally[20];
- health service efficiency, mostly of the public health system[12] with some limited attention to the contribution of private health insurance[21];
- quality and safety to provide value to the individual patients and the health system[22];
- long-term financial sustainability of the Australian health care system[11];
- prevention, diagnosis and management of chronic disease[23, 24]; and
- innovative funding models[25].

No review has been given the power to inquire into the health care system as a whole. Each appears to have been explicitly directed not to consider specific components of the health care system.

Yet, in 1997, the Industry Commission, when conducting an inquiry into private health insurance, called for a broad public inquiry into Australia's health system, encompassing but not limited to: health financing (including state/federal cost shifting incentives); integrated health systems and coordinated care; competitive neutrality between players in the system; and, safety and quality of health care. The Commission noted:

'it has become apparent from this inquiry that it is impossible to define the most appropriate role of private health insurance without determining how the bigger system is intended to function' [26]

In 2015, the Productivity Commission's *Efficiency in Health* report repeated the Industry Commission's recommendation. The Productivity Commission recommended a comprehensive and independent review to address systemic problems in the health system, including both administrative and financing structures which compromise system performance. While the Productivity Commission did undertake a further review in 2017[27] with a broader scope than the 2015 inquiry, the recommendation for a comprehensive and independent review still stands.

Only one Australian government commissioned inquiry has come close to a systemic review. However, despite the relatively expansive brief and resources given to the National Health and Hospitals Reform Commission (NHHRC) in 2008, and the then Minister's directive that the findings of reviews commissioned in parallel (on primary care, mental health and preventative health) be incorporated into the Commission's final advice, the NHHRC could consider only public health provision. It was unable to address either private health insurance, or private health care, including private hospitals. The public and private health care systems were to remain separately considered despite the extensive cross-over and interdependence between the two.

More recently, reviews that have been restricted in their terms of reference include the current *Medicare Benefits Schedule (MBS) Review* and the Productivity Commission's *Shifting the Dial (2017)* and *Efficiency in Health Inquiry (2015)*. The former was instructed not to consider the division of responsibilities between different levels of government[4]. Likewise, both the Productivity Commission reviews were asked to identify policy options to improve the operation of Australia's health care system without changing existing institutional and funding structures.

3.4 Health system challenges: considerable agreement

Notwithstanding the restrictions on their terms of reference, the reviews have largely agreed on the underlying challenges facing the health care system and the overall directions of change. In these findings, review groups have drawn on both Australian and international experience and developments over time.

The considerable agreement amongst the preceding range of reviews regarding Australia's health system challenges was summarized by the NHHRC as follows:

- large increases in demand for health services and expenditure on health care;
- growing burden of chronic disease and an ageing population;
- escalating costs of new health technologies;
- workforce shortages;

[4] The rationalization of roles and responsibilities between governments was assigned to the parallel Federation reform process. However despite a green paper being produced, the process was aborted in April 2016.

- costs and inefficiencies generated by the 'blame game and cost shifting' between levels of government;
- unacceptable inequities in health outcomes and access to services; and
- growing concerns about safety and quality.

Reviews have also often commented on the structural and financing barriers seen to impede responsiveness to changing health care needs, the overlapping roles and responsibilities between governments and providers, and the gaps in responsibilities generated by these.

3.4.1 Health system stewardship clarity of roles and responsibilities

Commonwealth/state relations

Whether at a local or national level, to varying degrees of specificity and across different time horizons, reviews have recommended improvements to system stewardship. Reviews have stated that:

- The current roles and responsibilities for the Commonwealth and states are unclear, have contributed to cost and blame shifting and are duplicative whilst, at the same time, leading to gaps in services. There has been no one government responsible for leadership, or stewardship, of the national health care system.
- This administrative complexity and cost is exacerbated by the multiplicity of agencies responsible for parts of the system within the Commonwealth.
- Without fundamental re-shaping of the administrative and governance arrangements between the service levels in health care – primary, community/secondary, and tertiary - coordination of services for the chronically ill is likely to remain complex and costly.

As the most broadly-based review, the 2009 National Health and Hospital Reform Commission (NNHRC) recommended that Commonwealth/state arrangements be reformed to ensure that Australia's health care system has the 'leadership and systems to achieve the best use of people, resources and knowledge'. Specifically, the NHHRC proposed the Commonwealth assume full responsibility for the policy and public funding of primary health care services; the purchasing of health services for Aboriginal and Torres Strait Islanders; providing universal access to dental care; public funding of aged care; and, government funding of all public health care services across the care continuum – both inside and outside hospitals[20].

Also in 2014, the National Mental Health Commission identified as its first strategic direction and recommendation in its Contributing lives, thriving communities report that governments set themselves clear roles and accountabilities. In support of this, the Commission recommended that there be agreement on and implementation of national targets and local organizational performance measures[28].

Similarly, the *Reform of Federation issues paper* in 2014 argued that clarification of roles and responsibilities between different levels of government would achieve a more efficient and effective federation that more closely met the needs of its citizens, and that would improve national productivity by reducing duplication.

Simplification of administrative arrangements

The number of national agencies established at the Commonwealth level to administer and monitor aspects of the health sector, and their various and diverse reporting and accountability responsibilities, have added and continue to add to the administrative complexity and cost of system governance. In the wake of the NHHRC report, the Commonwealth established eight new bodies to deal with specific aspects of the system – from prevention to pricing, quality and safety and workforce, in addition to the existing AIHW, quality and safety bodies and the Department of Health.

Unsurprisingly, subsequent reviews recommended rationalization of agencies. For example, the NCOA called for the consolidation of the 22 major Commonwealth health-related bodies and numerous associated boards, councils and committees in the Health portfolio. Specifically, the Commission proposed establishing:

- A National Health and Medical Research Institute to better align and embed health and medical research into the health system;
- a Health Productivity and Performance Commission, consolidating seven existing bodies to better coordinate, report and drive performance across Australia's health care system with a focus on measurable outcomes; and
- consolidating five other agencies into the Department of Health[29].

And other groups, such as the Business Council of Australia (BCA), had earlier called for the re-establishment of a health commission to take over long-term planning, funding and evaluation of health service financing and delivery[30]. [5] Although there has been some rationalisation of agencies at the national level, there continue to be numerous and diverse bodies and agencies with responsibility for various aspects of the operation of health services in Australia, with these operating under the mandate of several and different parts of the Commonwealth government and some under the auspice of the Council of Australian Governments.

Complexity defeats coordination across sectors

Successive reviews were unanimous in their agreement that greater clarity and separation of roles and accountabilities would improve service coordination within and across systems, address service gaps, reduce inefficiencies, and ultimately improve health outcomes. The historically different funding and service delivery arrangements in each sector have made the necessary level of coordination for chronically ill patients difficult and/or costly to achieve. Several reviews therefore proposed the simplification and alignment of administrative arrangements, such as the definitions and boundaries of delivery regions.

3.4.2 Health system financing

Public financing

This report has already noted in the preceding section that numerous reviews have called for a rationalization of the roles and responsibilities of governments within the federation to improve transparency and accountability. Health care is a major contributor to the vertical imbalance that characterises current Commonwealth/state relations and, in a situation in which roles and responsibilities

[5] In 1973 the Hospital and Health Services Commission recommended the existence of a separate Health Insurance Commission for 'Medibank', which would in 1984 become 'Medicare'.

are overlapping and complex, blaming the other level of government, and/or cost- shifting between levels of government occurs and efficiency and effectiveness, transparency and accountability suffer. This is notwithstanding that a key focus of the 2009 NHHRC was to propose a scheme by which the cost-shifting and 'blame game' for lack of performance was ended.

The National Commission of Audit (NCOA) cited the National Health Reform Agreement as an example of the unnecessary bureaucracy, cost-shifting and gaps in service that arise from duplication and lack of clear accountability for service delivery. [6] Under that agreement, both jurisdictions remain jointly responsible for funding public hospital services but with management of the public hospital system a state responsibility. Accordingly, the NCOA recommended hospital funding should be considered as a short to medium-term reform in the context of addressing vertical fiscal imbalance. Charged with proposing how to reduce the Commonwealth's structural deficit, NCOA proposed the Commonwealth limit its funding contribution to public hospital services to 45% of the growth in the efficient cost of services, abandon the previous commitment to increase that share to 50%, and, except for activity based funding, rapidly reduce reporting requirements[29].

Private health insurance vs public insurance

The Australian health system is mostly financed by public sources although with a substantial mix of both public and private insurance arrangements. In 2016-17, 68.7% of total health expenditures were publicly funded (41.3% by the Australian government, 27.4% by state and territory governments). The sources of non-public funding were: individuals (16.5%), private health insurers (8.8%), and accident compensation schemes (6.0 %)[17].

Some reviews have called for regulatory structures on the Private Health Insurance sector to be relaxed[27, 29] to allow private policies to become more attractive to consumers and improve the balance between demand on public health financing (Medicare) and private health insurance. The original purpose of Medicare was to provide a basic safety net for people who could not afford appropriate health care or private health insurance[31]. These reviews considered that Medicare had instead developed as a low-cost alternative to private health insurance, acting as a disincentive to the use of PHI for those who could afford to do so. The poor integration of Australia's public and private insurance schemes is considered to create further inefficiencies related to duplication, 'over-insurance', cost-shifting and perverse incentives regarding waiting times[32].

The Productivity Commission (2017) questioned the extensive limitations placed on private health insurance, including the risk equalisation measures (in the form of community rating) currently in place. Unlike most insurance products, private health insurance premiums are unrelated to the expected claim patterns of the individual (i.e. a 20 year old with low average claims will pay the same premium as a 70 year old with high average claims). This principle requires that insurers with healthier members bear some of the costs of insurers with greater representation of less healthy people. While this may be equitable, the Commission considered that this acts as a disincentive for PHIs to invest in prevention and further inhibits private policies from being able to compete with universal public insurance (Medicare).

The 2017 Commission review went on to state that if changes to risk equalisation were deemed unrealistic, as it has been considered a key pillar of private health insurance in Australia, then a cooperative and collaborative approach to manage and prevent chronic illness should be adopted by PHIs. With the

[6] In Australia, this refers to how the Commonwealth Government raises revenues in excess of its spending responsibilities, whilst the states have insufficient revenue from their own sources to finance spending

proportion of the population covered by private health insurance decreasing for the first time in 15 years, the Commission (2017) recommended all insurers invest in prevention in order to keep premiums stable and remain an appealing option for consumers against universal public insurance.

Remuneration and payment methods – setting the right incentives

Multiple reviews have focused on the need to change health care financing to promote equity of access for patients and encourage the efficient use of scarce health resources. They have also questioned the form of reimbursement that would best promote prevention and early detection and management of chronic disease.

Reviews have sought to understand what kind of behaviour the payment/reimbursement system encourages both in those supplying health care services and in those seeking health care. The latter is considered in the next section; here we focus on the incentives inherent in the fee for service model for providers that influence the right level of use of the right services by the right people.

In 2015, as part of its consideration of potential improvements in efficiency within the sector, the Productivity Commission found that current payment methods based on fee-for-service (FFS) promoted excessive use and volume, and that the provider payment model should better align financial incentives with policy objectives, such as the more cost-effective management of chronic disease, across the health care system. The Commission recommended that state and territory health ministers trial and evaluate new payment models, especially in primary care and that the Independent Hospital Pricing Authority introduce a quality and safety dimension to pricing within activity-based funding[12].

Similarly, in 2016, the Primary Health Care Advisory Group (PHCAG) to the Commonwealth government also supported new payment mechanisms, proposing the 'introduction of bundled payments, block payments and pooled funding to support the new approach, while preserving fee-for-service for episodic care'[25].

The 2017 Productivity Commission report echoed these points and recommended the establishment of Prevention and Chronic Condition Management Funds (PCCMFs) in each local health district (i.e. LHN/PHN area). The Commonwealth and relevant State or Territory Government would provide a modest amount of funding via a PCCMF, suggested to start at 2-3% of current activity-based hospital funding. The PHN and LHN would then collaborate to decide how and where to spend funds from the PCCMF, with the overarching goal of reducing potentially preventable hospitalisations related to chronic disease. This pooled funding model would provide a stronger focus on prevention with flexibility at the regional level.

Dampening demand; promoting greater self-management?

Demand for Medicare funded services is at an all-time high. While this has seen an increase in the GP bulk-billing rate, 2016-17 figures show that around one third of patients visiting GPs did not have all of their consultations bulk-billed in the previous year[33], illustrating that out-of-pocket costs (co-payments) are still commonplace for GP services. Reviews have given considerable attention to trying to assess the right level, if any, of co-payment that would encourage individuals to manage their health more proactively or to seek and maintain disease management regimes.

The NCOA considered the demand side of health service delivery, and recommended that those on

higher incomes take a greater responsibility for their own health care costs, but that everyone should make a small contribution to the cost of their own health care. The first recommendation effectively proposed changing Medicare from a universal insurance scheme to one that represented a safety net based on personal financial circumstances. NCOA's second recommendation for a universal minimum co-payment reflected its view that 'free' health care promoted over-use and a belief that co-payments would dampen demand for health care services without jeopardizing outcomes, and promote a more responsible health self-management culture.

In contrast, a 2014 Senate Inquiry[34] sought to discover whether the growing impost of co-payments and out-of-pocket expenses for individuals are deterring people from seeking early treatment, routine check-ups (for example, in dental care) and in taking prescribed pharmaceuticals. There has been, in recent years, vigorous debate about whether a lack of co-payments for those who are bulk-billed, combined with fee-for-service reimbursements to providers, encourages over-use of scarce resources and ineffectual treatment responses. However, in 2016-17, 4.1% of Australians reported that they delayed or did not visit a GP due to cost in the previous 12 months and 7.3% reported that they delayed or did not purchase prescribed medicines due to cost[35]. Furthermore, a 2017 OECD analysis found that 16.2% of Australian adults report that they skip medical consultations due to cost[36]. This illustrates the financial barriers that are faced by a significant proportion of the population, even with the current levels of bulk-billing.

Further to the NCOA (2013) recommendation around introducing a universal minimum co-payment, they also recommended that Government undertake analysis to improve the effectiveness of:

- Private health insurance arrangements to consider the system of prospective risk-adjusted payments, the role of private health insurance in primary care, regulation on 'improper discrimination', variation of community rating for a limited number of lifestyle factors and the extent of eligible insurance cover;
- the Extended Medicare Safety Net (EMSN) – which was initially introduced in 2004 to provide an additional rebate for Australian families and singles who incur out-of-pocket costs – is not meeting the principle of universality. In 2009, a review showed 20% of Australians living in the wealthiest areas received 55% of the extended safety net benefits, while the 20% living in the poorest areas received less than 4% of benefits. The Commission suggested the safety net should be targeted to protect the truly disadvantaged and not direct towards people who can afford to make an appropriate contribution to the cost of their health care as it is not meeting its objectives; and
- the Medicare Benefits Schedule (MBS), given that, when the NCOA report was completed in 2012-13, only 3% of the nearly 6,000 items on the list had been formally assessed against contemporary evidence of safety, clinical effectiveness and cost-effectiveness, and there was a need to identify and remove ineffective items[29].

These recommendations from the NCOA were in some respects synergistic with those from the PHCAG and the Productivity Commission (2017), which recommended maximizing the effectiveness of private health insurance investment in the management of chronic conditions and the pursuit of opportunities for joint and pooled funding[25, 27]. These reviews suggested pooled funding would enable funding from different organizations to be combined to create a single budget. A single local commissioning agency could then be used to commission integrated services in a region based on a common set of shared goals and outcomes for the population. The PHCAG and Productivity

Commission (2017) recommended that pooling of funds from different governments or portfolios represents better value for the health care system as this would:

- provide flexibility to address local gaps and challenges;
- provide opportunities to improve service integration;
- reduce service duplication and waste;
- overcome cost shifting; and
- deliver efficiency gains through lowering of administrative costs.

These recommendations appear to have been considered and reflected in the establishment of the MBS Review Taskforce, Private Health Ministerial Advisory Committee and the subsequent work of these two bodies (see section 4).

Allocation of financial resources – acute v. primary and community-based care; physical v. mental health

Reviews have recommended that not only should government amend reimbursement processes, but government should also consider the allocation of financial resources between different health care sectors. The National Mental Health Commission recommended that a minimum of $1 billion in Commonwealth funding for acute hospital services in five years of forward estimates from 2017-18 be reallocated to psychosocial, primary and community mental health services. This would represent a major reallocation from acute care to treatments for one of the most commonly incurred chronic disease groups.

3.4.3 Health service design and delivery

Most reviews adopted the generally accepted wisdom that effective management of chronic disease requires integrated and coordinated services from health and allied health professionals within each of the main health care sectors. The need for health care to continually evolve and adapt to changing environments and trends is evidenced by the various reforms and reviews undertaken in Australia since 1973. Coordinated, fit-for-purpose models of primary care are considered essential to a 21st century health system faced with the challenges of an ageing population and more chronic disease. The role of general practice and primary care services in reducing fragmentation of care was a focus of the Medicare Locals Review, which to a significant extent reflected recommendations of the Health and Hospital Services Commission in 1973. Both reviews recommended that primary care was the platform to strengthen comprehensive health care by providing improved care coordination for patients and that a renewed policy focus on out-of-hospital care was required to achieve this.

Efficiency and outcomes

Multiple reviews have agreed on the need to achieve an integrated health care system that allows and facilitates improved efficiency and outcomes through coordinated and better targeted care for patients with chronic and complex conditions. While based around a generally accepted model of care that is based in the primary or community-care sectors and utilising the services of specialists and allied health professional services as required and coordinated through a general practice, reviews have differed on the best way to encourage and support the faster adoption of integrated models of care.

For example, some, such as the Productivity Commission (2015) and the NCOA suggested that reshaping the health care 'market' by adopting principles of competition and deregulation would allow faster innovation. Others considered that empowering and promoting informed 'consumer' patients by building health literacy and enabling ready access to provider costs and quality/performance data would hasten the adoption of improved quality and efficiency.

Another Productivity Commission report from 2016, *Introducing Competition and Informed User Choice into Human Services Identifying Sectors for Reform*, recommended introducing the principles of competition and informed user choice in public hospitals, specialist palliative care services and public dental services to address inefficiencies and ineffectiveness in health service delivery[37]. This position was supported by the NCOA, which recommended that a more deregulated and competitive market, with appropriate safeguards, has the greatest potential to improve the health sector's competitiveness and productivity.

Primary care coordination for chronic conditions

In 2014, the Medicare Locals Review found that financing and service delivery in primary care remained fragmented despite government investment in integrated Medicare Locals because of the failure to undertake a fundamental restructure of the primary care sector setting. Lack of alignment of primary care boundaries with local hospitals networks meant that coordination between primary and acute sectors remained problematic; Medicare Locals had therefore not improved coordination or outcomes for patients consistently.

Accordingly, that review recommended a fundamental restructure of the primary health care sector to improve its effectiveness and efficiency, with the replacement of Medicare Locals by Primary Health Networks (PHN), the boundaries of which should align with Local Health Networks (LHNs). The review recommended that contracts between the PHNs and the Australian Government Department of Health should set clear performance expectations[19]. 31 Primary Health Networks were established by the Commonwealth across the country. Their establishment was aimed at improving administrative efficiency by consolidating all corporate, financial and administrative functions compared with the former Medicare Locals[38]. The closer alignment of PHN boundaries with existing LHNs has also created larger organisations with increased leverage as facilitators and purchasers of health care.

A National Evaluation of the Primary Health Network Program was jointly carried out by the University of New South Wales Centre of Primary Health Care and Equity (CPHCE), Ernst and Young and Monash University between July 2015 and December 2017. It found that in the absence of robust policy levers, PHN's power to directly influence the efficiency and effectiveness of medical service provision is limited. It describes the very "lean" nature of most PHN operating models and states that without sufficient resources, PHNs will be hindered in their ability to meet future expectations. However, it concluded that '*the PHN Program has the potential to help address some of the key structural challenges which impact the ability of the Australian health care system to provide efficient and effective services across the continuum of care'[39]*

Additionally, the PHCAG recommended a risk stratification 'medical home' approach to guide health service design, and identified three tiers of the population who may benefit, differing in complexity and need for coordinated care. This approach was adopted in the Health Care Homes Model (see section 4.2).

3.4.4 Health care quality and safety

Most reviews have seen the need to improve quality and safety across the health care sector as a very specific challenge that undermines health outcomes, and that also is a driver of waste and inefficiency in the sector. In 2009, the NHHRC recommended that the then temporary national safety and quality body be established on a more permanent basis to address the persistent issues of adverse events[7] and variation. There was also a strong focus on accreditation for both health professionals and health care organisations as a means of improving the consistency and quality of practice across a dispersed and mixed public/private health care.

A later research paper by the Productivity Commission in 2015 estimated that a 20% efficiency improvement could be achieved in health care expenditure by getting all hospitals up to best practice levels and the MBS Review suggested that up to 30% of health care expenditure was unnecessary.

3.4.5 The enablers – health workforce; information and research; medical products and technologies

New health care roles

Several reviews have suggested workforce related changes, such as expanding the scope of practice of some allied health professionals, redefining roles and utilizing contemporary technologies to improve efficiency and flexibility. These include:

- The Productivity Commission (2015) recommended that amending scope of practice, based on evaluations of past and current trials, would lead to greater workforce flexibility and satisfaction and potentially lower labour costs[12].
- The National Mental Health Commission also recommended redesigning professional roles (particularly pharmacy with a renewed focus on General Practice) to enable a new, population-based system architecture to implement a new model of coordinated and integrated care.
- Extending the current scope of health professional practices (for example, pharmacists and nurse practitioners) to address the future needs of Australia's health care system was endorsed by the NCOA.
- The Productivity Commission (2017) recommended that the Australian Government should embrace technology to change the pharmacy model and role of pharmacists. It suggested introducing automated dispensing of medicines in a majority of locations, supervised by a suitably qualified person, to improve efficiency and shift the role of pharmacists to a more clinical one. The Productivity Commission anticipated this would allow pharmacists to collaborate more with other primary health professionals and play a greater role in patient care[27].

Best practice guidelines

The Productivity Commission (2015) suggested that a greater focus on evidence-based guidance for clinicians and patients would promote clinically and cost-effective health care practice, and recommended establishing an expert panel of clinicians to assess and endorse guidelines, and to advise on dissemination, implementation and review of service delivery. This was echoed in the Productivity

[7] Adverse events are defined as incidents in which harm resulted to a person receiving health care and include infections, falls resulting in injuries, and problems with medication and medical devices.

Commission's 2017 recommendation to eliminate low-value health interventions, by improving the dissemination of best practice advice to clinicians and trying to dampen demand for low-value services by providing more information to consumers.

Information and communication technology

Various reviews, including the NHHRC, strongly supported the key elements of Australia's first national e-health strategy after its release in 2008, agreeing that digitization and faster adoption of ICT within the sector would significantly improve access, quality outcomes and enable better utilization of scarce resources to improve the integrity, utilization and timeliness of patient data. However, since the national e-health strategy was adopted, several reviews have continued to identify improving the use of health information as a major recommendation.

3.5 The most recent comparative review – Organisation for Economic Cooperation and Development (OECD)

Finally, this report presents the findings of the most recent comprehensive comparative study of Australia's health care system. Undertaken by the OECD in 2015, the review found that the Australian health care system is 'too complex for patients'[40]. Its recommendations emphasised the need for simpler and more coordinated pathways for patients with chronic conditions, greater focus on improving the quality of outcomes across all sectors and the need to strengthen the primary care sector. The OECD considered rationalization of the roles of CW and States in primary care and an improvement in the relations between the two levels of government as essential preconditions to system improvement. In 2017, the OECD also published comparative data on a set of key health system performance indicators[36]. While not as comprehensive as the 2015 study, it offers further insight into the strengths and weaknesses of Australia's health system and a snapshot of system performance against other OECD countries.

The failure to solve the mix of roles and responsibilities in each of the health care sectors, together with Australia's slowness in adopting electronic health technologies, reforming the payment system to medical practitioners, providing information about performance to both peers and the public, and improving systematically the quality of care, were all considered in the OECD report to be major impediments to Australia's capacity to keep pace with other countries' health performance improvements.

3.6 Summary

- Hospital services are provided by state and territory governments and by private for profit and not for profit organisations. Primary care services are provided mostly by private organisations and individuals with some provided by not for profit organisations. Funding for both hospital and primary care services is a complex mix of taxpayer funding, private health insurance funding and individual co-payments
- Funding and service provision for health reflect historical divisions and the broader vertical imbalance that characterizes Australia's federated structure and the complex interplay of relations between the Australian government and state and territory governments.

- There have been successive reviews of the Australian health system; governance, financing and service delivery. Most of the reviews have been partial and driven by specific concerns –funding growth, workforce shortages, waiting lists, variation in outcomes or gaps in service.
- Despite the pressures appearing to warrant a systemic response, a long- standing recommendation for a systemic review that encompasses both public and private health care service provision and funding has yet to be taken up.
- Most reviews, notwithstanding their partial coverage, have acknowledged major concerns regarding the:
    - financial sustainability of the system;
    - perceived gaps in services or variations in health outcomes and/or access; and
    - the need to adapt to a changing disease pattern.
- Review recommendations have been consistent with international thinking and practice about the cost-effective management of chronic disease:
    - new models of care to deliver better health outcomes and care;
    - new forms of payment to restructure incentives for service providers and users to encourage greater efficiency;
    - improved quality and a greater focus on prevention, early diagnosis and management of chronic disease; and
    - greater coordination in patient pathways.

4. Responses and reforms

Today's challenge is chronic disease prevention, diagnosis and management. The idea that health policy now requires a strong focus on chronic disease burden is not new, and it has been a focus of both current and previous Australian governments who have acknowledged it as a significant challenge. There is broad consensus that unless we make fundamental changes, the costs of preventable illness and resulting health care demand will continue to be a major issue for governments and individuals alike[32]. However, the ineffective management of chronic disease is still abundantly clear across Australia's health service arrangements.

Ineffective management of chronic disease is:

- Driving significant increases in the use and demand for medical and diagnostic services and pharmaceuticals, while at the same time, leading to significant losses in workforce participation and productivity [8];
- estimated to be costing the Australian health care system more than $320 million each year in avoidable admissions; and
- leading to variations in health status and outcomes.

Chronic disease:

- Contributes to two-thirds of the difference in death rates between Aboriginal and Torres Strait Island and non-Indigenous people[41].
- Disproportionally affects and impacts socioeconomically disadvantage people[42]. For example:
    - Cancer sufferers living in lower SES areas have lower survival rates[43].
    - Coronary heart disease (CHD) has a 40% higher death rate and has demonstrated a lesser rate of decline over time among people living in areas of lowest socioeconomic status compared with those in the highest[44].
    - Australians living in these same areas of disadvantage were 1.7 times as likely to report having 4 or more risk factors for chronic disease than their more affluent counterparts[45].
    - Early deaths from major chronic diseases are significantly higher in lower socio-economic groups. Between 2013 and 2017, 49,227 more people died from chronic diseases before the age of 75 in the most disadvantaged 40% of the Australian population, compared to the least disadvantaged 60%[42].
    - People in the most disadvantaged areas are 57% more likely to be obese and 60% more likely to be living with diabetes than those in the least disadvantaged[42].
    - Smoking rates are 2.5 times higher in the most disadvantaged communities[42].

Not only do states and Commonwealth governments share responsibility for health services, but services are provided through a mix of public and private providers and are financed by a mix of public

8 As of 2004-05, $7b per annum was lost from people not being able to attend work (absenteeism) and $18-25b per annum is lost to decreased performance at work. Decreased productivity worsens with multi-morbidity. 59% of people with three or more chronic diseases were not in the workforce or unemployed, compared to 19% of people with no chronic diseases.

and private payers. This mix of public and private - together with its federal structure - creates a complex and loosely coupled set of Australian health care services. The emergence of chronic disease however, means it is more important than ever for the series of services and financing mechanisms to operate as a system to meet the complex needs of patients suffering from chronic disease. Such coordination has proved extraordinarily difficult to achieve.

As might be expected when there is no clear and authorised leader or system steward for health, progress in realigning services and financing to deal with chronic disease more efficiently and effectively has been slow and hard-fought. But change has occurred. Here, the response to the various reviews are considered and initiatives which have been agreed, implemented or partially implemented, outlined. Each of the major reviews has had a government response. These are detailed in Appendix 2.

4.1. Health systems stewardship

Several reviews have recommended that the roles and accountabilities between the Commonwealth and States be clarified; some called for national leadership of (or parts of) the system. For example, the NHHRC recommended that a national steward be established to help plan and monitor implementation of a long-term vision for health care in response to the emerging health needs arising from chronic disease. The Commonwealth's response[46] to the NHHRC recommendations was pursued in two ways.

The first was via changed funding arrangements, in the form of new Commonwealth / State agreements. The most significant of these related to a major proposed change to responsibilities and funding for public hospitals, whereby the Commonwealth would assume the role of major funder for public hospitals, based on a nationally efficient price, in exchange for States agreeing to forgo one-third of their GST receipts. The original Commonwealth proposal sought to reduce the role of the States as managers of the public hospitals systems by paying hospitals directly and making them 'subject to' prices, performance and quality standards set by Commonwealth statutory authorities. They would however remain responsible for funding 40% of the efficient price and any overruns on actual costs above the efficient price. These proposals were rejected by the States and Territories and amendments made. The National Health Reform Agreement that was struck in 2011 provided for phased increases in funding by the Commonwealth to 50% of the nationally efficient price by July 2017[47]. At the same time, national partnership funding agreements which set out roles and responsibilities, including funding, were established through COAG for primary and community health, mental health and preventative health measures.

Appendix 4 outlines the history of policy in relation to public hospital funding after the NHHRC. It shows not only the impact of a change of direction between two major reviews – the NHHRC and the National Commission of Audit – but also the results of:

- the Commonwealth's position on how to implement the review recommendation;
- the subsequent results of the negotiations with the states on that proposal; and
- the changes to that negotiated outcome by the Commonwealth in subsequent budget rounds.

The second way in which the Commonwealth responded to the NHHRC recommendations was to establish new Commonwealth statutory authorities to advise on specific aspects of the system. The National Quality and Safety Commission, the National Health Performance Authority, the Independent Hospital Pricing Authority and the Health Workforce Agency were charged with bringing national

uniformity to, and improvement in the efficiency, effectiveness and quality of outcomes of, their respective spheres.

The result is that the original NHHRC's recommendations:

- to establish a nationally efficient price for hospital services is implemented;
- to establish national performance standards is largely preserved but not yet achieved (see next section); and
- to undertake a comprehensive review of MBS items to ensure both clinical relevance and best practice is underway.

However, the agencies established to pursue these major initiatives have been dramatically changed. Following acceptance by the Commonwealth of NCOA recommendations, several of these have now been abolished, with their functions having been transferred either to other agencies or subsumed within the Department of Health. The most recent attempt to clarify and rationalize roles and responsibilities was through the Reform of the Federation process, although this was aborted in 2016.

4.2 Health system financing

Commonwealth/State divisions

As noted above, the reviews of system financing have been restricted to consideration of the split between Commonwealth and State/territories, with greatest focus on public hospital funding. Although considerable effort has been made, there have been only minor changes to roles and responsibilities in practice.

Public vs private insurer

Governments are not the only health funders responding to changing models of care needs. Private health insurers are also responding to the changing pattern of health care use and needs of their clients, especially as they seek to both manage their total cost exposure and add value for their customers. The first means that they share an interest in boosting prevention of chronic disease, together with early treatment of any conditions that do develop. However the restriction on their capacity to provide cover in the mainstream primary care sector means they must look to innovation in promoting managed care through new forms of partnership with primary care providers and to add cover for allied health services as part of their policy cover. They are seeking to redesign services to reflect the incidence of chronic disease and the benefits of prevention. For example, Medibank's Care Complete package is designed to complement the Medical Homes initiative; payments for extras that relate to healthy activity or complementary medicine are aimed at boosting health status and reducing risk factors, and the introduction of telehealth services/doctors on call seeks to ensure ready access to early treatment. The anticipated pay-off is lower acute care costs.

Redesigning remuneration and provider payment

Fee-for-service vs blended payments

As noted in Section 3, several reviews [12,25] called for a change from the pure fee-for-service payment model for providers as a way of changing the balance of incentives away from use and volume of services to outcomes and efficient service delivery. Under fee-for-service reimbursement schemes, health care providers can be incentivised to supply a greater amount of services than required. This supply-induced demand creates inefficiency in the provision of health care [32].

In late 2016, the Health Care Homes trial was announced and commenced in late 2017. This initiative will support coordinated care and flexible funding models for patients with complex and chronic conditions. Specifically, a blended per capita payment scheme is provided for chronically ill patients (on an opt-in basis). The PHCAG recommended the better targeting of services for patients with chronic and complex conditions in accordance with need could be achieved by drawing on existing validated Australian and international risk stratification tools to identify patients requiring high levels of coordination and team care.

For example, estimates could be made via existing utilization data to identify the intensity of care support required for Australians with chronic diseases. This could be broken into three tiers.

Tier 1: Multiple morbidity but low complexity, patients are largely high functioning and largely self-managing their care.

Tier 2: Increasingly complex multiple morbidity, patients requiring increases access to services, are likely to be on multiple pharmacotherapies, but are able to function in the community with appropriate support.

Tier 3: Highly complex multiple morbidity, patients requiring frequent ongoing care within an acute setting, including those with cancer requiring complex care, or patients with severe, persistent and treatment resistant mental illness.

The Health Care Homes Model augments previous changes to the MBS schedule that reimburse GPs for developing chronic illness management plans, such as the Diabetes Care Project. The Productivity Commission (2017) was positive regarding the Health Care Homes concept, but was critical that key aspects of the model were still set at the national level, limiting regional flexibility. It stressed that the Commonwealth would need to collaborate more with LHNs and PHNs and provide improved regional flexibility in the distribution of funding for the model to deliver the best possible outcomes. As of June 2018, there were less than 2000 patients involved in the scheme, well below the projected 65,000 enrolments.

Activity-based funding and the establishment of a National Efficient Price

The National Hospitals Reform Agreement provided for public hospitals to be funded based on activity and the national efficient price for each activity. Although this continues a focus on volume, the arrangement seeks to improve efficiency and outcomes by reducing the level of variation in efficiency and outcomes among the different hospitals within specific groupings.

Continuing refinements are being made to the prices and elements of reward for improved quality outcomes will be trialled soon.

The National Disability Insurance Scheme (NDIS)

Disability and aged care reform were considered out of scope for the purpose of this report, despite the obvious links intertwined through all three sectors. However, the development, launch and ongoing implementation of the NDIS (dating back to 2008), provides a significant example of major structural reform regarding service design and disability care financing[48, 49].

The NDIS was considered an innovative way of providing individualised support for people with disability, their families and carers. Any Australian with a permanent and significant disability, aged under 65, is eligible for the scheme and once accepted will be provided with the reasonable and necessary supports they need to live an ordinary life. Eligible people, known as participants, are given a plan of supports which is developed and tailored to their individual needs[48].

The new scheme signified a shift towards a more consumer directed model of care, whereby the participant, their family and/or their support staff play a more active role in deciding what reasonable and necessary supports would best serve the participant in reaching their goals. The participant is provided with a sum of money depending on the supports requested within their plan, but they are then responsible for choosing their own service providers, encouraging flexibility and promoting service innovation.

Some block payments (payments direct from the Australian Government to service providers) are still required, particularly in rural and remote areas[48], but the shift towards a nationwide consumer-directed individualised payment model is a flagship piece of reform, which has not yet been emulated in the health sector.

MBS Review and Private Health Insurance Reforms

Recommendations from multiple reviews contributed to the establishment of the MBS Review Taskforce in 2015, and the subsequent General Practice and Primary Care Clinical Committee in October 2016 [25, 29]. The former is tasked with assessing more than 5,700 MBS items against contemporary evidence, clinical effectiveness and cost effectiveness and the latter is a series of advisory groups that provide the necessary clinical expertise to the Taskforce. In their 2018 report, the General Practice and Primary Care Clinical Committee made 18 recommendations to the MBS Taskforce aimed at encouraging 'more proactive engagement in prevention' in general practice settings[48].

As of April 2018, the Commonwealth had accepted over 80 MBS Review Taskforce recommendations [49], aimed at ensuring MBS items are best practice and evidence-based. This has included the removal of obsolete items and the modification of many others that were not in line with current best practice. Despite this, a major recommendation provided by the Productivity Commission (2017) centred on governments revising their policies to more rapidly reduce the use of low-value health interventions that were not evidence based or considered best practice[27]. This recommendation proposed a suite of actions in addition to the MBS review; including the creation of more comprehensive 'do not do' lists for low-evidence surgical interventions, quicker responses to international assessments and evidence, and improved dissemination of best practice guidelines to clinicians.

The Private Health Ministerial Advisory Committee (PHMAC) was also established in 2016 to review all aspects of private health insurance and provide government with advice on reforms[50]. The PHI reforms introduced in 2017 were largely based on recommendations from the PHMAC. The majority of reforms focussed on improving information and choice available to consumers by[51]:

- developing easy to understand categories of private health insurance (basic, bronze, silver and gold);
- upgrading the privatehealth.gov.au website to make it easier to compare insurance products;
- allowing insurers to expand hospital insurance to offer travel and accommodation benefits for people in regional and rural areas that need to travel for treatment;
- requiring insurers to allow people with hospital insurance that does not offer full cover for mental health treatment to upgrade their cover and access mental health services without a waiting period on a once-off basis; and
- increasing the maximum excess consumers can choose under their health insurance policies for the first time since 2001.

Additionally, some reforms related to lifetime health cover loading and medical device subsidies were aimed at improving price incentives and affordability. In line with the Productivity Commission's (2017) recommendation, the reforms also barred PHIs (which are subsidised by the taxpayer) from offering rebates for certain natural therapies with no proven efficacy (e.g. homeopathy and naturopathy).

Insurer vs patient – co-payments and out-of-pocket expenses

However, there have also been recommendations (for example, from the NCOA) to increase the level of co-payments for primary care and pharmaceuticals, and to reduce the level of subsidy for those paying for private health insurance. These have not been implemented, despite some attempts to do so. In some cases, alternative means, such as the GP schedule benefit freeze, were adopted to achieve the same ends. Indeed, there have been follow-up reviews - for example Senate Inquiries - which have reviewed the level, incidence and consequences of out-of-pocket expenses and justifications for health insurance premium increases[34]. In January 2018, the Ministerial Advisory Committee on Out-of-Pocket Costs was established in response to the Senate Inquiry into *value and affordability of private health insurance and out-of-pocket medical costs.* The major focus of the committee is to identify ways to improve transparency around out-of-pocket medical costs[52].

4.3 Health service design and delivery

Reviews have recommended action at two levels in relation to service delivery. The first is clarification and rationalisation of the delivery responsibilities between the Commonwealth and states; the second is the need to facilitate the development of new models of care for chronic disease that span and utilise health care services provided across both public and private sectors. This report has outlined changes to the first in section 4.1 above. Here the report focuses on what has been implemented in relation to the new models of care and the changes in structural arrangements between health care sectors.

Models of care for chronic disease

The major redirection proposed by most reviews relates to seeking greater coordination of services for those with chronic illness. All governments have accepted the need to strengthen the primary care sector; to facilitate easier and more streamlined communication of both clinical and financial information to reduce duplication, improve the accuracy and timeliness of data transfer within and between sectors; to target and encourage the prevention, early detection and management of chronic disease (and reduce preventable hospital admissions); and, to encourage the take-up in practice of the most recent best clinical practice by updating the MBS and PBS schedules. Initiatives include:

- continuous review of Pharmaceutical Benefit Scheme (PBS) items to ensure that the right drugs are available at the right time, while at the same time discouraging use of obsolete or less effective drugs and allowing savings from those that are out of patent to be shared with funders and/or patients; and
- changes to the Medical Benefit Schedule (MBS) as a result of the ongoing MBS review and allowing additional payments to encourage the use of telehealth, early detection and management of chronic conditions by GPs.

Restructuring primary care; realigning primary and acute care

Medicare Locals and Local Hospital Networks were established as a means of encouraging the development of integrated primary care service centres and improved linkages between primary and acute care. In 2014, the Medicare Locals Review found that the anticipated improvements had not been realized and so recommended that the structure of the primary care sector itself be changed and better aligned to the local hospital networks. These recommendations were accepted, and in 2015 the establishment and implementation of Primary Health Networks began. More recently, the Productivity Commission (2017) recommended pooled funding via Prevention and Chronic Condition Management Funds be provided to LHNs and PHNs to encourage collaboration and the development of innovative chronic disease prevention activities at a local health district level[27].

4.4 Health care quality and safety

Although the WHO framework identifies quality and safety as a function of the building blocks, this section specifically considers those recommendations and initiatives that have related to quality and safety. The first review of safety and quality in Australia occurred in 1995, titled the Quality in Australian Health Care Study (QAHCS). It found that upwards of 10% of people admitted to Australian hospitals suffered an 'adverse event' attributable to inadequate quality and safety protocols. In response to this study, multiple taskforces and advisory groups were set up in the late nineties, culminating in the establishment of the Australian Council for Safety and Quality in Health Care in 2002. However, a 2005 review found the Council's effectiveness was limited by inadequate links between the Council, jurisdictions and other key stakeholders, a narrow focus on safety in the acute sector and its large size and unwieldy internal arrangements. This prompted the dissolution of the Council after 5 years and the establishment of the now permanent Australian Commission on Safety and Quality in Health Care (ACSQHC).

The ACSQHC has undertaken a more structured and purposeful program of work since its inception in 2006. First, 10 national standards in patient care that addressed the most commonly occurring adverse

events, were promulgated in 2011. Of the 10, 7 related to clinical practice and the remaining three addressed governance and patient role and engagement. Since then, 98% of hospitals and day surgeries have been assessed to determine their adherence to the standards. In parallel an accreditation and assessment process for primary care practices has also been established. Secondly, the regular reports of performance of individual institutions are published on the My Hospitals and My Healthy Communities website as information to prospective patients. Funding to hospitals is intended to increasingly be adjusted for avoidable errors.

The most recent initiative, which continues the theme of implementing standardization of practice and adherence to best practice clinical guidelines has been the publication of the *Australian Atlas of Health care Variation*. This *Atlas* has highlighted large unwarranted variations in practice and is the basis upon which States and their local health boards will launch investigations and redress practice[53].

At the same time, private health insurers are also moving to advise patients on quality performance and in some cases, refusing to pay for avoidable errors rectification.

4.5 The enablers – health workforce; information and research; medical products and technologies

Workforce for the 21st Century – numbers, portability, and role scope

The workforce issues considered by various reviews include an apparent shortage of medical professionals (doctors and nurses); a mal-distribution of these; and, the changing skill mix needed to underpin the changed pattern of disease and appropriate models of care. Health Workforce Australia (HWA) was responsible for planning for "a skilled, flexible and innovative health workforce" before its closure in 2014. Its scope included not only providing advice about the levels and kind of training for home-grown graduates, but also strategies for recruitment and retention of internationally trained professionals. While the 'essential functions' of HWA were transferred to the Department of Health, a national, coordinated approach to health workforce planning and regulation continues to be critical to help governments better match demand for health professionals with supply.

An expansion by the Commonwealth of the number of training places offered by universities for both doctors and nurses addressed the apparent shortage; changed tax incentives and conditions associated with immigrant medical professional for rural and regional location sought to address mal-distribution of health professionals.

In addition, recommendations from the NHHRC and the Productivity Commission (2015), among others, stressed the need for national portability to facilitate easier transfer of resources between areas within Australia and to develop new roles that allow better utilization of skills. National registration and accreditation procedures for existing health professional roles have been established, together with recognition of new roles such as nurse practitioners. There have also been changes to give greater scope for allied health professionals, such as pharmacists and practice nurses, to undertake routine functions, formerly only in scope for GPs. While these changes were introduced to dampen the demand for GPs, other reforms that have seen some common drugs removed from sale and available only on prescription are likely to offset some of the potential reduction in demand.

But it is not only the scope of roles that is changing. It is also the setting. For example, the introduction of 24/7 nurse on-call services has been designed to take pressure off emergency departments and

as noted earlier, telehealth services are being progressively introduced to provide improved range of specialist and diagnostic services in rural and remote areas.

Information and research

A national e-health strategy – building infrastructure to connect services and improve utilization of information

Recognising that building connectivity within and between Australia's health care services was fundamental to both reducing complexity and streamlining patient journeys and improving the utilization of scarce resources, the first national e-health strategy was adopted by the Australian Council of Health Ministers in 2008.

Both Commonwealth and state governments have made significant investments both in the digitization of patient records (the Personal electronic health record) and in building transferability and connectivity to support transfer of data between providers. The significance of and investment in the universal e-health record is undermined by a debate affected by mistrust in large government-funded data bases and misuse of personal information by large private companies. As recently as 2017, the OECD characterised Australia as 'relatively poor' in its capacity to collect and link health data and the Productivity Commission (2017) described the current information sharing systems as messy, partial and prone to duplication[27].

Empowering and engaging individuals

The second way in which information is being used to reshape the health sector is by trying to rebalance in part the asymmetry of information between individuals and health professionals. The reviews have all basically accepted the premise that effective chronic disease management requires individuals to be more actively engaged in managing their own health, risk factors and health care costs.

However, the reviews differed in their emphasis between two strategies. Those reviews that were more closely focused on financial sustainability of the system (and staffed accordingly), such as the NCOA and the Productivity Commission, emphasised the use of information transparency and co-payments (see above) to contain demand and encourage prevention and self-management. Other reviews that were more focused on health outcomes and staffed by health professionals, such as the NHHRC and the National Preventative Health Taskforce, tended to emphasise the need to increase health literacy and programs that would make it easier for individuals to identify and manage their health risks.

To make performance and financial information about providers more readily accessible to patients, as consumers, the Commonwealth government developed the My Hospitals website and subsequently required the quality and performance authorities to publish their key data. It also made it compulsory for providers to advise on the total costs of treatment prior to a patient receiving that treatment. Although reviewers have recognised the special nature of the health care market and in particular the asymmetry of information, one of the perceived benefits of standardizing and digitizing electronic health records is the facilitation of the option for patients to transfer to another provider in addition to the obvious benefit of integration of care between several providers for individuals.

The second element in engaging people more closely in managing their own health and health care was by improving their health literacy and capacity to manage their own risk factors and conditions (under GP supervision). The Commonwealth, in partnership with the States, local government, schools and employers, instituted preventative health programs incorporating early detection programs, physical

fitness and education programs. Introduced progressively from 2008, these have been abandoned with the termination of the National Partnership Agreement on Preventative Health in 2015. In place of the National Partnership Agreement on Preventative Health, the CW, through the NHMRC and additional funding from the Medical Research Future Fund, now supports the Australian Prevention Partnership Centre which has a considerably narrower scope and significantly less funding.

Research

The reviews into Australia's medical research directions have been specific, although more broadly based reviews, such as the NHHRC, strongly supported the need for ongoing investment into medical research.

There are three drivers for the reviews. The first is a desire to continue to expand the knowledge base about the chronic diseases that now dominate – how they develop, early detection techniques and cost-effective treatment options. The second is a move to hasten the uptake of the most recent research findings into clinical practice, both as a way of improving outcomes, but also to reduce variation in outcomes and streamline treatment paths as the new models of care develop (see above). And third, governments have recognised that research and evaluation are important tools to underpin and support change within the health care sector itself.

Public funding for medical research is significant, but so too are the expected returns. Governments as investors expect that discoveries will be commercialised and provide financial returns to research institutes. They also consider the resources as an investment in the adaptation of the sector.

Medical products and technologies

The third enabling building block relates to infrastructure more generally – both facilities and capital equipment and technologies.

Most major reviews, including the NHHRC, have recognised that the changing pattern of disease and the need for more distributed, but connected services requires a changed configuration of facilities. This includes care settings but also sophisticated equipment that can be available through a distributed service network.

While the NHHRC identified the need for more sub-acute facilities and greater use of care provided in community settings, together with greater integration of planning between the aged care, social care and health care sectors, the reviews of each sector continue to be focused on one rather than the interconnections between the two. Notwithstanding this there have been attempts to improve particularly the provision of primary care in aged care settings and to encourage the development of more sub-acute care settings to provide care for chronic and complex conditions.

The private sector is a major investor in alternative care settings, both within health care and the aged care sector. Although the growth in capital expenditure over the decade to 2014-15 was slightly higher than the growth in private expenditure, in that year, the total investment by the private sector exceeded that of the public sector[17]. Most day surgeries are now occurring in private sector facilities.

4.6 Summary

- Governments have responded to each of the major reviews. Recommendations have not been accepted in their entirety and reform proposals have been amended to fit political priorities of the time or because of compromises needed to achieve agreement with implementation 'partners'.
- While there has been an acceptance of the predominance in chronic disease and the need for some adjustment to allow development of new models of care, the reforms have so far not embodied a substantial redesign of the system stewardship or financing of health care services.
- In particular, the clarification and rationalization of roles and responsibilities between the different levels of government has yet to occur.
- The level of public hospital funding has tended to dominate negotiations, although advances have been made in introducing and maintaining initiatives to improve efficiency and quality.
- Similarly, the failure to consider private and public health care service provision and financing holistically means that the system of multiple payers and providers continues.
- Despite this, and the difficulties encountered in getting agreement to changes, some change has occurred. These changes are consistent with international trends to new models of care for those with chronic conditions.
- Investments are being made by all governments and the private sector in ongoing research, infrastructure (physical and electronic, care settings and equipment) and workforce to underpin the greater focus on primary, community and sub-acute care and the need for interconnectivity between all parts of the health care sector and other social care sectors. However as Boxall pointed out [16], the decision-making processes that govern these investments remain disconnected and uncoordinated.

5. Progress and impacts of changes

Are the reviews and their outcomes sufficient to meet the challenges facing the system or to address the issues of equity and efficiency identified by the reviews? In this section, we first review the data against each of the original Medicare principles and the documented health challenges in each WHO system component. The report then considers the most recent findings by the OECD on Australia's health care performance.

The chairs of two of the more prominent reviews have undertaken an assessment of the outcomes of their work.

In 2013, five years after handing the NHHRC report to the government, its chair, Dr. Christine Bennett, reviewed progress[54]. The government's 2010 response to the review accepted 48 of the NHHRC's 123 recommendations, supported a further 45, noted another 29 and rejected 1. The 2010-11 budget claimed $7.3b in new funding to support implementation of the recommendations across the three major reviews (NHHRC, the Primary Care strategy and the National Preventative Health Strategy).

In 2013, Dr. Bennett found that 44 of the NHHRC recommendations were being implemented as proposed, 61 had been amended or only partly implemented, and 16 had not been implemented[54].

The Chair's conclusion was that by 2013:

*While there has been some valuable progress, **we have not yet resolved the structural flaws in funding and governance that fragment health care delivery in Australia. We have focused largely on public health financing and public hospitals** (AHPC emphasis) but have not yet considered innovative approaches, such as Medicare Select, to better use the private sector. (p254)*

Moreover, Dr. Bennett said:

The Commission described sub-acute care services as the "missing link" in the continuum of health care. A key reform investment by the federal government has been to support development of sub-acute care, such as stroke recovery, rehabilitation services and palliative care, as part of a National Partnership Agreement with the states. However, funding is due to expire in June 2014.

End-of-life care and advance care planning initiatives are being explored, and aged care services reforms were the subject of a Productivity Commission inquiry in 2010. While not embracing some of the fundamental reforms, the government is implementing recommendations to expand community and home-based care options and simplify the assessment process. (p252)

In 2016, the Chair of the National Preventative Health Taskforce reviewed progress since its report was handed to government. Despite the introduction of major programs funded under the National Partnerships Agreement (now terminated) the Chair's conclusion was:

Australia invests less in prevention than do other comparable countries, and our investment is declining[9]. The burden of (non-communicable diseases) NCDs is high; more than seven million Australians are living with a chronic condition, and we are failing to meet most of the national targets set by COAG and the NPHS in 2009.

9 For example, in the 2013-14 financial year, spending on public health (which includes prevention activities) was only 1.53% of total recurrent spending, and is declining as a proportion

NCDs have a high personal, social and national economic impact. ***If we seek to achieve significant reductions in the burden of chronic disease in Australia, sustained, comprehensive and courageous approaches are required*** *(our emphasis)[9].*

The major conclusions of these two chairs are those of this review of reviews – that:

- some change has been made in the right direction;
- fundamental structural changes are still required and the lack of these are significant impediments to performance improvement; and
- a long and sustained effort is required.

5.1 Sustainability of the system – can we afford it?

5.1.1 Expenditure growth

The reviews identified the rapid growth in health expenditure as a challenge to future financial sustainability of the system. Have the initiatives taken so far slowed the demand for services and the rate of growth in health care expenditure?

This will be considered in two parts: by reference to actual expenditure and then by reference to levels of demand.

Australia spent nearly $181 billion on health in 2016–17 – equating to more than $7,400 per person. This represents a larger increase in spending than recent years, after four years of below average expenditure growth. Health expenditure growth (adjusted for inflation) was 4.7% in 2016–17 – 1.6 percentage points higher than the average over the past 5 years (3.1%) and higher than the average over the decade for the first time since 2011–12. In terms of overall economic activity, health expenditure accounted for 10.0% of GDP in 2016-17, down from 10.3% the previous year, but still above the OECD median average of 9.1%[71].

As a proportion of total government tax revenue, health expenditure increased from 25% in 2013-14 to 27.1% in 2016-17, reflecting the continuing growth in demand and cost of services[17]. This is the highest proportion of government health expenditure from tax revenue since 2011–12, and only slightly lower than the decade peak of 27.2% in 2009–10 (when tax revenue was heavily impacted by the GFC).

In 2016–17, the real growth of government health expenditure across all levels of government grew by 6.8%, 2.3 percentage points higher than the decade average of 4.5%. Conversely, non-government expenditure, consisting of costs borne by individuals, private health insurers and other non-government sources, had a growth rate of only 0.2% in 2016–17. This was the lowest annual growth rate in the past decade and a fraction of the decade average of 4.8%.

However, over the last five years, the overall proportional share of government vs non-government expenditure has remained stable. Government expenditure has increased from 68.3% to 68.7% and non-government expenditure has decreased from 31.7% to 31.3%. Within non-government expenditure, the proportion of costs borne by individuals via direct payments has seen the largest adjustment (from 17.8% to 16.5%), funding from private insurers has increased (from 8.1% to 8.8%) and funding from accident compensation schemes and other non-government sources has remained stable (5.7% to 6.0%)[17].

However, whilst the proportion of overall health care expenditure funded by individuals decreased in the five years from 2011-12 to 2016-17, there was still $29.8 billion spent by consumers on health-related expenses in 2016–17—60.3% more than they spent in real terms in 2006–07 ($18.6 billion). More than two-thirds (67.8%) of health expenditure by individuals was for primary health care in 2016–17, including $5.9 billion (19.6%) on dental services[17].

5.1.2 Efficiency improvements – the National Efficient Price

The largest item of expenditure is on public hospitals, which treat 3 of every 5 hospitalised patients. The 2011 National Health Reform Agreement signed by the Council of Australian Governments included the introduction of activity-based funding based on a national efficient price (NEP), which was considered a major step towards improving efficiency in public hospitals. The NEP underpins activity-based funding and can be used as an independent benchmarking tool to measure the efficiency of public hospital services[55]. A 2018 report on hospital performance showed that efficiency and the rate variation across hospitals had improved since the introduction of the NEP[56]. However, there was still considerable variation across the sector and many consider efficiency gains through the NEP to be limited, given the associated funding still focuses on the volume of services provided, rewarding activity as opposed to outcomes and innovation[27, 57].

Another factor in improving efficiency is improving utilization of capital infrastructure. While process reengineering projects are being undertaken across the system, there are limits on improvement due to the availability of professional staff and/or local demand. In his report on the utilization of Victoria's public hospital system, for example, Travis[58] found that across the 86 health services in Victoria, although there were 1,436 inpatient points of care (POC) that could be used immediately, the available unused capacity was not uniform across the services and did not necessarily line up with demand.

5.1.3 Chronic disease management—fit-for-purpose and measures of capacity

One of the implications of both the prevalence of chronic disease and the increasing effectiveness and cost of treatment options afforded by new technologies is that traditional ways of measuring capacity in the health care system are no longer relevant. New treatments and technologies have dramatically reduced the length of hospital stays and have enabled varied and dispersed care settings, including people's own homes. Travis used the alternative term 'points of care' to replace the traditional 'bed' measure, to cover many kinds of inpatient facilities (such as chairs for same-day treatment, ward beds, trolleys, rehabilitation beds or intensive care unit (ICU) beds). These points of care (POC) are markedly different physically, have widely different capacity to treat patients, and are not readily substitutable for each other[58].

As Travis noted, capacity measures need to answer the two fundamental questions the public constantly asks:

Will I be able to get treatment if I am sick?

How long will it take to get treatment?

Rather than counting 'beds', better answers to these questions are given by reference to the average time to clear waiting lists; the percentage of people treated within clinically appropriate times, and the average waiting time for a first consultation in an outpatient clinic.

In assessing progress, this report will shortly seek to consider these measures. But first, a brief overview of nominated priorities from the reviews:

- Are we making progress on prevention?
- Are we reducing potentially preventable hospitalisations by treating earlier?
- Are we allocating expenditure across disease types to reflect the changed incidence?
- Has communication of information improved to ease patient journeys and reduce duplication?

Progress on prevention and early management of chronic diseases

As noted above, progress on reducing risk factors that contribute to the 30% of disease considered preventable is slow. Investment in primary care services with a prevention focus has been limited, although some progress has been made. Vaccination rates have improved and injury rates fallen. However, while risky behaviours such as smoking and dangerous-level alcohol consumption continue to fall, and obesity levels as measured by current methodologies and metabolic diseases associated with diet and other health risk factors continue to rise.

A 2014 study of chronic disease and GP consultations between 2009 and 2013, found that about half of the people (44% to 56%) who visited a GP once in a year had one or more chronic conditions such as back pain, high cholesterol, arthritis, type 2 diabetes, asthma and anxiety and they took 51% to 66% of consultation time [59]. However, GPs actively manage these conditions in just 34% to 50% of consultations through activities such as counselling, prescription medicines or referral to a specialist and GPs in some parts of Australia are up to twice as likely to prescribe drugs for some common health conditions such as depression and heart disease compared to doctors in other areas.

Investment in mental health primary care services has reduced unmet demand but there remains significant unmet demand, especially in regional areas.

Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPHs) are hospitalisations considered to have been avoidable if timely and adequate non-hospital care had been provided, either to prevent the condition occurring, or to prevent the hospitalisation for the condition. This measure has been adopted by COAG as an agreed indicator of the extent to which people are being given either a preventative or the right treatment as early as possible in the course of illness; that is, in accordance with the best practice for effective management of chronic disease.

In 2015-16, 6.4% or 680,000 of all hospitalisations were deemed potentially preventable[60]. Between 2010–11 and 2015-16, the overall rate of potentially preventable hospitalisations fluctuated between 23.9 and 26.4 per 1,000 population. The rate of PPHs attributable to chronic conditions rose from 11.4 to 12.0 in that time and the rate of vaccine-preventable hospitalisations increased from 0.7 to 2.0 per 1,000 population[60].

However, the overall rate of potentially preventable hospitalisations was around 3 times the rate for Indigenous Australians than other Australians; was highest for people living in Very Remote areas, and was generally higher in lower socio-economic areas.

Communication between and across – progress with e-health

The development of an electronic infrastructure to connect the system of dispersed and disparate health care services and underpin quality and efficiency improvements has now been underway for over a decade. In its final report the former NEHTA noted both progress and lessons learned:

Compared to other global electronic health record implementations, Australia's national electronic health record is in its early stages. Australia is well positioned to move into an era of continued implementation – focusing on enhancing usability, patient and provider registration and better sharing of clinical information.

and

Significant achievements have been made to date in the Australian eHealth agenda, under NEHTA's leadership. These achievements have created a solid foundation from which adoption, usage, and innovation in digital health can flourish. With widespread usage, digital health can be expected to deliver significant health system and population health benefits [61].

Coverage is increasing with public and some private hospitals but take-up of the personal e-health record among those using primary care is significantly lower. Australia's national electronic health record (*My Health Record*) has changed from opt-in to opt-out in early 2019 to encourage greater uptake of the system, both from individuals and health care providers.

Coordination of patient journeys

The Patient Experience Survey (2016-17) showed an improvement in coordination of care, with 70% of those who saw three or more health professionals for the same condition, reporting that a health professional (usually a GP) coordinated their care and only 12% reporting that there were issues caused by a lack of communication between the health professionals[62].

5.2 Access and equity; gaps in service?

The demand for health services arising from the spread of chronic disease is increasing. The NHHRC reported that gaps in access were evident due to three major factors – rising financial imposts; lack of services in areas where chronic disease has grown fastest, and underfunding of fastest growing disease types. Some attempts have been made to redistribute the workforce, provide access through enhanced use of telehealth and patient transfer services and increased funding for illnesses such as mental illness to reflect its growing incidence and impact. Are they enough?

From 2000 there has been a significant increase in the number of training places for doctors and nurses. These, together with continued immigration of overseas trained doctors and nurses, have seen the full-time equivalent rate per 100,000 people rise to 400 for doctors and 1145 for nurses and midwives in 2016[4]. However, the distribution of health professionals continues to be uneven, with the AIHW reporting in 2015 that there were 442 employed medical practitioners per 100,000 people in Major Metropolitan areas and only 263 per 100,000 in Remote or Very remote areas[63]. The spread of specialists was heavily clustered to large population centres[63].

In assessing progress, data on the distribution of health professionals and facilities provide some information. But deferral of treatment because of cost and waiting times are the real tests.

Financial barriers for individuals

The effects of increased individual payments continue to vary across groups and locations. For example, less than 4% of benefits from the Extended Medicare Safety Net (EMSN) are distributed to the 20% of the population living in Australia's poorest areas but the 20% living in the richer areas received more than 50% of benefits[64]; and, between 2007-2014, out-of-pocket costs for Medicare services increased overall by 25% in real terms on average, but in very remote areas, payments increased by 41%[65].

More importantly, a 2011 study showed that increasing levels of direct payments affected those who most regularly access the health care system, namely those with chronic disease and the elderly[66]. Furthermore, a 2017 OECD analysis of health indicators found that 16.2% of Australian adults report that they skip medical consultations due to cost, well above the OECD average of 10.5% [36]. Avoidance or delay in seeking or receiving medical care is associated with living in an area of greater socioeconomic disadvantage[62]. The Australian Bureau of Statistics Patient Experience Survey (2017-18) found people living in areas of most socioeconomic disadvantage were:

- more likely to have not received appropriate specialist care;
- twice as likely to have delayed or avoided getting prescribed medication due to cost;
- twice as likely to have delayed or avoided seeing a dental professional due to cost;
- over 60% more likely to visit a hospital emergency department; and
- half as likely to have private health insurance, when compared with people living in areas of least disadvantage[62].

Indigenous Australians claim an average of 10% more MBS GP services per capita compared with non-indigenous Australians. However, claim rates for specialist services (which are more likely to incur out-of-pocket costs) were 43% lower for Indigenous Australians, further illustrating the financial barriers faced by some individuals in accessing best practice, specialised medical care.

Access to services:

Despite significant expansion in the number of doctors and nurses since 2000, the OECD considers the uneven distribution of these to be one of Australia's key challenges in providing equitable access to health care[40]. Incentives and rules to increase the level of health professionals working in rural and remote areas have been inadequate to offset the 'pull' of metropolitan and regional centres, with the fee-for-service payment model exacerbating the disadvantages for remotely located professionals. The OECD is also critical of both the slow take-up of telehealth and changed scope for health professionals that would allow better utilization of the health workforce that does exist. Once again, the OECD sees the fee-for service payment model as a block to more radical change, together with inadequate infrastructure.

Waiting times:

The Victorian government Patient Experience Survey (2016) found that there were improvements in access more generally in that jurisdiction. While a significant number of patients believed they waited too long to see either GPs or specialists, the numbers had reduced since the previous year and access to after-hours care was improving.

The 2017-18 AIHW health performance and hospital statistics show that:

- The median waiting time for elective (non-urgent) surgery of 40 days was 2 days more than 2016-17 and 4 days longer than 2013-14. The 90th percentile waiting time (the amount of time within which 90% of patients were admitted for the awaited procedure) increased slightly from 260 days in 2013-14 to 268 days in 2017-18, and the number of people waiting longer than 365 days decreased from 2.4% to 1.8%[67]. However, there is still significant place-based inequality, with waiting times longer than 365 days increasing in South Australia and Northern Territory over the last 5 years.
- In emergency departments: the number of people presenting has grown on average by 2.7% p.a. in the five years from 2013 and the most recent report shows an increase of 3.4% from 2016-17 to 2017-18. The proportion seen on time has decreased from 75% in 2013-14 to 72% in 2017-18. The 90th percentile waiting time (the time by which 90% of presentations were seen) increased from 93 minutes in 2013-14 to 99 minutes in 2017-18[68]
- The development of sub-acute and other community-based care facilities is slow and not showing major impacts in reducing waiting lists. For example, between 2013-14 and 2016-17 the number of sub-acute beds available on average across the country's 39 sub-acute and non-acute hospitals dropped from 67 to 66. The investment in beds, both acute and sub-acute, continues to be clustered in large population centres[69].

However, this data masks the true waiting times. As demonstrated in Victoria's report on waiting time for specialists in the public system, patients can wait for months to have their first appointment and before they are accepted on to formal surgery waiting lists, even for urgent matters. Patients with health care needs considered routine can wait for several years, depending on which specialist and hospital they have been referred to[10].

The National Bowel Cancer Screening Program provides a classic example not only of long waiting times, but also of how the split of federal and state responsibilities can lead to poor implementation of a program designed to improve outcomes for a common cancer. This cancer has a 90% survival rate if detected and treated early. The Australian government funds and administers the screening program and provides funding to the states for follow up diagnostic procedures. The states however struggle with waiting lists and access to specialist resources and care facilities. As a result, Bowel Cancer Australia reported in 2016 that only 17% of those who tested positive on the initial screening test and required a follow up colonoscopy were seen in the recommended 30 days. The median wait time was 55 days but could be up to a year depending on where the patient lived. Participants who self-identified as Indigenous, participants who lived in *Very remote* areas and participants who lived in low socioeconomic areas had higher screening positivity rates, yet had a lower follow-up diagnostic assessment rate and a longer median time between a positive screen and assessment[70].

10 See as an example – Victoria's Specialist Clinics Activity and Wait Time Report, June quarter 2015–16 – PRELIMINARY http://performance.health.vic.gov.au/Home/Resources/Publications.aspx

5.3 Quality variation and improvement

The establishment of national safety standards, together with national accreditation of health professionals and institutions, show slow improvement in the quality of care. Data is beginning to flow but remains difficult to aggregate and is sparse for primary care.

As the OECD notes:

> *'a surprising lack of data on outcomes and quality of care marks Australia out from its peers …. (especially) in primary care which has an under-developed pay-for-performance scheme and in rural and remote areas'[40].*

However, the Australian Commission on Safety and Quality in Health Care has identified improvements in quality as institutions progressively adopt and are monitored against the national standards. For example, between 2010 and 2015, the Commission reported[71]:

- a decrease in hospital-acquired infections due to greater prioritisation of antimicrobial stewardship activities in hospitals (the number of hospitals with antimicrobial stewardship increased from 36% in 2010 to 98% in 2015);
- better documentation of adverse drug reactions and medication history;
- reduction in the yearly red blood cell issues by the National Blood Authority between mid-2010 and mid-2015, from approximately 800 000 units to 667 000 units;
- early warning or track and trigger tools in 96% of recognition and response systems in 2015, compared with 35% in 2010; and
- declining rates of intensive care unit admissions following cardiac arrests.

At a state level, in-hospital cardiac arrests in Victoria and New South Wales have declined; South Australia has reduced the number of extreme harm incidents involving falls by more than 50% since 2011; in Queensland, hospital-acquired pressure injuries have continued to decline, and Western Australia has maintained its previous improvements in the same area[69].

In 2016-17, 1 or more adverse events resulted in, or affected, about 601,000 hospitalisations (5.5% of all hospitalisations). This compared with a rate of 5.3% in 2011-12. The most recent results show again that adverse events were generally higher for overnight hospitalisations compared with same-day hospitalisations (11.1% and 1.8%, respectively); in subacute and non-acute care settings where stays are typically longer (for which lengths of stay are typically longer - sub-acute 7.3% and acute 5.6%), and among emergency admissions compared with non-emergency admissions (9.7% and 3.9%, respectively)[69].

These results show that since adopting a more structured approach and embedding quality into funding and accreditation processes (from which access to reimbursement and payment depends) there is some improvement in safety and quality. However, Australia remains in below average categories compared with similar OECD nations against many international benchmarks[36, 40].

5.4 Comparative performance – the latest OECD data

OECD comparative data published in 2015 shows that all countries are slowly improving the quality and efficiency of their health care but too slowly to cope with the rise in chronic disease[40]. Australia is no exception. Although it does well in terms of coverage of health care, it is only a middle performer on waiting times and has one of the highest rates of out-of-pocket expenses in the OECD[36, 40]. Its outcomes and quality of care range from one of the top performers (on certain cancer survival rates, AMI) a middle performer on other cancers and diabetes, but a low performer for asthma and COPD, and strokes[36, 40]. Its recent expansion in doctor numbers, paralleled by a similar expansion in other OECD countries, has delivered a middle-of-the-field position, but its expansion of nurse numbers has meant that Australia has one of the higher nurse/ per capita ratios. The 'mal-distribution 'of these professionals is however also noted. Australia appears well served by its investment in CT and MRI equipment, but is seen as a slow adopter of e-health despite the obvious advantages in offsetting access difficulties in rural and remote areas[40].

5.5 Summary

- Health expenditure has slowed but is still rising faster than GDP with that expenditure being financed from non-government sources, including individuals.
- A rise in out-of-pocket expenses is leading to more Australians experiencing cost as a barrier to health care.
- On average, people are waiting longer for elective surgery and the proportion of people being seen on time in emergency rooms has decreased. The average number of available beds in subacute facilities has also descreased.
- Apparent improved efficiency hospital costs is not translating into improved financial performance for many hospitals, especially in regional and rural areas.
- The distribution of services between geographic areas and income areas continues with only minimal improvement for most in terms of access and outcomes. As one of the slower countries to adopt changed scope of practice and/or new roles, under-utilisation of workforce skills is exacerbating Australia's problems.
- The *Closing the Gap* program does show some improvements for indigenous Australians although the reduction in risk factors is slow and will take many years to effect significant outcome improvements.
- Despite a decade-long program to address patient safety matters, the chosen indicators show only small improvements and on many indicators a 2015 OECD comparative study showed Australia lagging the average OECD performance.
- Reviews of progress by chairs of two of the major reviews confirm that some useful changes have been made but the lack of much more fundamental restructuring has impeded progress and that a sustained and consistent effort is required to ensure that adaptation occurs optimally.

- The most recent OECD comparative study reinforces these findings, stating that the fragmented and complex mix of roles and responsibilities was impeding reform progress and that continued reliance on a fee for service payment system was perpetuating many of the difficulties, including the emergence of more effective management of chronic conditions and maldistribution of health.

6. Incrementalism and ongoing structural flaws – what is needed now?

This report has considered the findings of the many successive reviews of the Australian health care system. It has shown that all have agreed that the fundamental challenge facing Australian health care is how to meet, and dampen, the exponential rise in demand for health care that arises from the growth in chronic disease. Half of all Australians have a chronic disease and many live with two or more. Today's health services and system arrangements are still structured to meet the health care needs of the past – acute illness, infectious disease and trauma. Today's health needs require coordinated and sustained health care for individuals that includes multiple disciplines and care settings. Adaptation in the way health care is delivered and financed has been emphasised throughout the reviews as essential.

Recommendations have differed depending on the brief for the review, report or inquiry, the expertise of the appointed panel and the context in which it was established. So for example, those undertaken with a health services brief focused very closely on what was required to encourage the spread of new models of care for chronic disease while improving the quality and safety of existing services. Others, presented with the need to find ways to arrest the growth in health expenditure and to dampen demand for publicly funded services, focused on new ways of financing the system and improving its efficiency, including reducing waste and 'error' rates. All looked to the decades-long experience of other countries in tackling these twin issues.

But while the reviews, reports and enquiries all presented similar findings about the nature of the challenge and agreed the need for adaptation in the configuration of health care services to meet a changed pattern of disease, they differed in both the emphasis they gave to the importance of governance, financing and service delivery matters, and the specifics of how to implement new structural and clinical care models. In part this reflected their restricted terms of reference; in part, it reflected the continuing pursuit internationally for the best way forward.

What this report has shown is that, despite the clear evidence of the problems and pressures that have led to reviews, the reviews themselves have been restricted and their recommendations have only led to incremental reforms that have also been restricted and less than effective. The Australian health care system continues to be characterized, therefore, by multiple payers and providers, split between different levels of government and across public and private sectors. The universal public insurance scheme superimposed on this mixed system in 1974 created only a loosely coupled system of health care. It is one that responds well to emergencies and catastrophic events but in other respects is unwieldy and difficult to navigate for both reformer and patient.

This report recognises that change has occurred and successive governments have introduced initiatives consistent with both international best thinking and the original ideals of Medicare. In other words, the changes made thus far have been true to the values of the Australian community as embedded in the principles of Medicare and at the same time are consistent with the broad directions needed to cope with chronic disease.

But are the incremental reforms moving fast enough? Are they keeping pace with the growing demands for both service provision and funding? Although much of the data continues to be partial and dated, the trends suggest that services are only just keeping pace with demand.

The rate of public expenditure on health care has slowed, but at the expense of non-government funding sources, including from individuals. Services are being expanded and official waiting times

marginally improved but the development of new services specifically focused on the needs of those who are chronically ill are slow to emerge. For example, the rate of preventable hospital admissions which measures the extent to which both early and effective management of chronic disease is occurring and the availability of lower cost alternative health care settings, has improved only marginally and is basically stable, despite state auditors and health performance monitors publicising the rates over a decade or more. Similarly, those who have chronic conditions, such as cancer and diabetes, living in rural, remote or lower socio-economic areas continue to have lower survival rates because of the difficulty they have in accessing services.

A recent OECD comparative review diagnosed the Australian health care system as 'too complex for patients' and recommended a much stronger focus on both outcomes and quality across all sectors and reducing the extent of variations in these across the country. For that reason it proposed changing the financial reimbursement arrangements for health providers from the volume-encouraging fee-for-service arrangements alone to reward quality and outcomes. It also suggested that despite the advances in providing more information for funders and patients alike, there was still room for expansion of this performance data.

And finally, when assessing the state of the health care system against the original goals set by the architects of Medicare – universal, equitable, simple and affordable - this report has concluded that with the advent of chronic disease, a major redesign of the current configuration of health care services and their financing is necessary. Failure to do so will mean that the system will continue to have gaps in services and differential access due to rationing and slow changes to allocations between areas and diseases; it will not become simpler to navigate and its administrative costs for all participants will not be reduced. More importantly it will continue to absorb scarce resources and to undermine the very nature of a universal insurance scheme as providers seek to shift costs to others in the system. Ultimately this will be to individuals with the increasing prospect that Australia will return to the pressures and problems of the 1970s with many faced with rising and unaffordable health care costs.

Priorities for change

The significant reviews undertaken of the Australian health care system in recent decades have had limited impact. This report concludes that the reviews have distilled and concurred on the same core priorities for change. The reviews overwhelmingly reflect and reinforce the need for structural reforms that are also articulated as system building blocks in the WHO Health System Performance Assessment Framework.

There are major structural barriers that the reviews have identified and substantially agreed on. These include a lack of nationally agreed stewardship goals and strategies to regulate and shape the health services sector. Development of clinically and cost-effective health services relevant to contemporary health needs requires reshaping of the flows of revenues and costs between states, the Australian government, private health insurers and individuals and to change historical payment arrangements to facilitate efficiency and reduce complexity. The most recent OECD study nominated the continued fragmentation of government responsibilities, especially in the important area of primary and community health care, and the dated fee-for-service payment method for treatment of those with chronic disease as key priorities for change. Indeed, the constraints arising from the limited terms of reference given to successive reviews have resulted in recommendations that are primarily focused on incremental reforms and it is evident that even this is difficult to implement.

Australia's system of government and private funding of health care services delivered by a complicated mix of private and public sector employment and self-employed health professionals mean that the levers for change are limited and any changes in regulation or payment will affect businessviability and incomes. It is unsurprisingthen that resistanceto any changeis strong and vocal and the centrality of life/death and health fears to the community mean that debate will alwaysbe difficult. It is for this reason that a public debate that is well grounded in evidence and an understanding of likely consequences, together with a bi-partisan and long-range strategy are essential to ensuring that change continues in the right direction.

As a result, this report considers the priorities for development are:

- First, establishmentof a permanent national stewardshipstructure to develop andoverseethe implementation of a long-term plan for the system, based on realising the goals of Medicare. A permanent national stewardship structure – potentially a National Health Commission would be jointly owned by national, state and territory governments and would have responsibility for policy advice to governments on three major priorities addressingcritical health care priorities and components of an efficient and effective health system:
    - achieving singular stewardship across all level of governments;
    - the ongoing strengthening of primary care through more integrated and easyto accessservices;and
    - a sustained focus on prevention at all levels of health care.
- Second,restructuring of current health care financing arrangementsto provide simpler and efficient health care,more focused on outcomes andquality while providing the incentives for the right care to the right people at the right time. This would include consideration of:
    - the coverageof a publicly funded universalinsurancesystem,together with the role of private health insurance,in the context of funding care for chronic conditions

      and;
    - the basisof reimbursement to providers to encouragesustainedprevention, early detection and management of chronic diseaseand coordination of services to reduce duplication and more effective use of information.

References

1. Biggs, A., Medicare–Background Brief. 2004: Canberra: Parliamentary House.

2. Australian Prudential Regulation Authority, Statistics: Private Health Insurance Membership and Coverage. 2018, APRA.

3. Sammut, J., Fiscal Fiction: The Real Medicare Levy. 2017, Centre for Independent Studies.

4. Australian Institute of Health and Welfare, Australia's Health 2018, in Australia's Health series no. 16. AUS 221. 2018, AIHW: Canberra.

5. Australian Institute of Health and Welfare, Australia's Health 2014, in Australia' health series no. 14. Cat. no. AUS 178. 2014, AIHW: Canberra: AIHW.

6. Australian Institute of Health and Welfare, Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. . 2016, AIHW: Canberra.

7. World Health Organization, Social Determinants of Health. 2008, WHO Regional Office for South-East Asia.

8. Willcox, S., Chronic diseases in Australia: the case for changing course: Background and policy paper. 2014.

9. Moodie, R., P. Tolhurst, and J. Martin, Australia's Health: Being Accountable for Prevention. Medical Journal of Australia, 2016. 204(6): p. 223-5.

10. Australian Institute of Health and Welfare, OECD health-care quality indicators for Australia 2015, in Cat. no. PHE 209. 2016, AIHW: Canberra.

11. Commonwealth of Australia, 2015 Intergenerational Report: Australia in 2055. 2015, Department of the Treasury: Canberra.

12. Productivity Commission, Efficiency in Health. 2015, Australian Government: Canberra.

13. Armstrong, K. and S. Dyson, Who Will Fund Our Health? Actuaries Institute Green Paper. 2014, Actuaries Institute Australia: Sydney.

14. Australian Government Department of Health, Expenditure and Prescriptions Twelve Months to 30 June 2017. 2018, DoH: Canberra.

15. Australian Government Department of Health, Medicare Diagnostic Imaging Statistics – Financial Year 2004-05 onwards. 2018, DoH: Canberra.

16. Boxall, A., What are we doing to ensure the sustainability of the health system? 2011, Parliamentary Library: Canberra.

17. Australian Institute of Health and Welfare, Health expenditure Australia 2016-17, in Health and welfare expenditure series no. 64. Cat. no. HWE 74. . 2018, AIHW: Canberra.

18. Commonwealth of Australia, Budget 2017-18: Budget Overview. 2017, Department of Treasury,: Canberra.

SCI.0001.0041.0066

19. Horvath, J., Review of Medicare Locals: Report to the Minister for Health and Minister for Sport. 2014, Department of Health.

20. Bennett, C., National Health and Hospitals Reform Commission: A Healthier Future for All Australians Final Report. 2009, NHHRC: Canberra.

21. Commonwealth of Australia, Private Health Insurance Consultations 2015-16, Department of Health, Editor. 2016: Canberra.

22. Australian Government Department of Health. Medicare Benefits Schedule Review 2018; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce.

23. Commonwealth of Australia, Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy 2010, Department of Health Canberra.

24. Commonwealth of Australia, Australia: The Healthiest Country by 2020 – National Preventative Health Strategy – Overview. 2009: Canberra.

25. Primary Health Care Advisory Group, Better Outcomes for People with Chronic and Complex Health Conditions Through Primary Health Care: Discussion Paper. 2015, Department of Health,: Canberra.

26. Industry Commission, Private Health Insurance. 1997: Canberra.

27. Productivity Commission, Shifting the Dial: 5 Year Productivity Review, in Report no. 84,. 2017, Australian Government Canberra.

28. National Mental Health Commission, Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services. 2014, NMHC: Sydney.

29. National Commission of Audit, Towards Responsible Government: The Report of the National Commission of Audit, Phase One. 2014, NCOA: Canberra.

30. Business Council of, A. Letter to the Health Minister. 2009; Available from: http://www.bca.com.au/docs/15D0F52C-EFC2-4CCD-94F3-D8562C9D164B/letter_to_health_minister_nicola_roxon_re_supervision_and_governance_of_the_health_sector_final_16-12-2009.pdf

31. Scotton, R.B. and C.R. Macdonald, The Making of Medibank. 1993, Sydney: School of Health Services Management, University of New South Wales.

32. Paolucci, F. and M. García-Goñi, The Case for Change Towards Universal and Sustainable National Health Insurance & Financing for Australia: Enabling the Transition to a Chronic Condition Focussed Health Care System. 2015, The Australian Health Policy Collaboration, Victoria University: Melbourne.

33. Australian Institute of Health and Welfare, Patients' out-of-pocket spending on Medicare services. 2018, AIHW: Canberra.

34. Senate Community Affairs Reference Committee, Out-of-pocket costs in Australian healthcare. 2014, Commonwealth of Australia: Parliamentary Library.

35. Productivity Commission, Report on Government Services 2019, in Health Sector Overview. 2019, Australian Government Canberra.

36. OECD, Health at a Glance 2017, in OECD Indicators. 2017: Paris.

37. Productivity Commission, Introducing competition and informed user choice into human services: identifying sectors for reform. 2016, Australian Government: Canberra.

38. Australian Government Department of Health. Primary Health Networks (PHNs). 2016; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home.

39. Centre for Primary Health Care and Equity, Evaluation of the Primary Health Networks Program - Final Report, E. Young, Editor. 2018, UNSW: Sydney.

40. OECD, OECD Reviews of Health Care Quality: Australia 2015: Raising Standards in OECD Reviews of Health Care Quality. 2015: Paris.

41. Australian Health Ministers' Advisory Council, Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report. 2012, AHMAC: Canberra.

42. Harris, B., H. Fetherston, and R. Calder, Australia's Health Tracker by Socio-Economic Status 2017. 2017, Australian Health Policy Collaboration, Victoria University: Melbourne.

43. Australian Institute of Health and Welfare, Cancer in Australia: An Overview, 2012. 2012, AIHW: Canberra.

44. Australian Institute of Health and Welfare, Trends in Coronary Heart Disease Mortality: Age Groups and Populations: Cardiovascular Disease Series. 2014, AIHW Canberra.

45. Australian Institute of Health and Welfare, Australia's Health 2016. 2016, AIHW: Canberra.

46. Australian Government Department of Health, Three Major Reform Projects Responded to in the 2010-11 Budget. 2010, DoH.

47. Council of Australian Governments, National Health Reform Agreement 2011, COAG.

48. Whalan, J., P. Acton, and J. Harmer, A review of the capabilities of the national disability insurance agency. NDIS: Canberra, Australia, 2014.

49. Baker, A., The new leviathan: A national disability insurance scheme. 2012: Centre for Independent Studies Sydney.

50. The General Practice and Primary Care Clinical Committee, Medicare Benefits Schedule Review Taskforce: Report from the General Practice and Primary Care Clinical Committee Phase 2. 2018.

51. Australian Government Department of Health, Government response to recommendations of the Medicare Benefits Schedule Review Taskforce. 2018, DoH.

52. Australian Government Department of Health, Private Health Ministerial Advisory Committee. 2018, DoH.

53. Australian Government Department of Health, Private health insurance reforms: Overview. 2018, DoH.

54. Australian Government Department of Health. Ministerial Advisory Committee on Out-of-

Pocket Costs. 2018; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/min-advisory-comm-out-of-pocket.

55. Australian Commission on Safety and Quality in Health Care, Second Australian Atlas of Healthcare Variation, in Australian Atlas of Healthcare Variation Series. 2017, ACSQHC: Sydney

56. Bennett, C.C., Are we there yet? A journey of health reform in Australia. Medical Journal of Australia, 2013. 199(4): p. 251-255.

57. Solomon, S., Health reform and activity-based funding. The Medical Journal of Australia, 2014. 200(10): p. 564.

58. Australian Institute of Health and Welfare, Hospital performance: Costs of acute admitted patients in public hospitals from 2012–13 to 2014–15. 2018, AIHW: Canberra

59. Duckett, S.J.,et al., Controlling costly care: a billion-dollar hospital opportunity. 2014, Grattan Institute: Melbourne, VIC.

60. Travis, D., Travis review: Increasing the capacity of the Victorian public hospital system for better patient outcomes. 2015, Victorian Department of Health: Melbourne

61. National Health Performance Authority, Healthy Communities: GP care for patients with chronic conditions in 2009–2013. 2014, NHPA: Sydney.

62. Australia Institute of Health and Welfare, Potentially preventable hospitalisations 2015-16, A.G.D.o. Health, Editor. 2017, AIHW: Canberra.

63. National E-Health Transition Authority Ltd., Evolution of eHealth in Australia : Achievements, lessons, and opportunities. 2016, NEHTA: Sydney.

64. Australian Bureau of Statistics. Patient Experiences in Australia: Summary of Findings, 2017–18. 2018 [cited 2018; Available from: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0.

65. Australian Institute of Health and Welfare, Medical practitioners workforce 2015, D.o. Health, Editor. 2018, AIHW: Canberra.

66. Van Gool, K., et al., Extended Medicare Safety Net review of capping arrangements report 2011: . 2011, Centre for Health Economics Research and Evaluation.

67. Duckett, S., P. Breadon, and J. Farmer, Out-of-pocket costs: hitting the most vulnerable hardest-Grattan Institute submission to the Senate Standing Committee on Community Affairs Inquiry into the out-of-pocket costs in Australian healthcare. 2014, Grattan Institute Carolton, VIC.

68. Essue,B., et al., We can't afford my chronic illness! The out-of-pocket burden associated with managing chronic obstructive pulmonary disease in western Sydney, Australia. Journal of health services research & policy, 2011. 16(4): p. 226-231.

69. Australian Institute of Health and Welfare, Australian Hospital Statistics 2017-18: Elective Surgery Waiting Times. Health Services. 2018, Canberra: AIHW.

70. Australian Institute of Health and Welfare, Emergency Department Care 2017–18: Australian Hospital Statistics, in Health services series 2018, AIHW: Canberra.

71. Australian Institute of Health and Welfare, Australia's Hospitals 2016-2017 at a Glance, in Health services series no. 85. Cat. no. HSE 204. 2018, AIHW Canberra.

72. Australian Institute of Health and Welfare, National Bowel Cancer Screening Program: Monitoring Report 2016, in Cancer Series No.: 98. 2016, AIHW.

73. Australian Commission on Safety and Quality in Health Care, ACSQHC Annual Report 2017–18. 2018, ACSQHC: Sydney.

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Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017)	Analyse Australia's productivity performance in both the market and non-market sectors, prioritising potential policy changes to improve Australian economic performance and the well-being of Australians by supporting greater productivity growth.	Australia's fragmented funding and governance systems for healthcare — which largely reflects Australia's federal system and its hybrid private-public nature — work against achieving the best outcomes for a given overall expenditure. There is a need to create better structures and new incentives that promote efficient prevention and chronic illness management throughout the health system.	Public consultation processes, public submissions awnd consultation with Commonwealth, state and territory governments.	1. Implement nimble funding arrangements at the regional level: The Australian, State and Territory Governments should allocate (modest) funding pools to Primary Health Networks and Local Hospital Networks for improving population health, managing chronic conditions and reducing hospitalisation at the regional level. 2. Make the patient the centre of care: All Australian governments should re-configure the health care system around the principles of patient-centred care, with this implemented within a five year timeframe. 3. Eliminate low-value health interventions: Australian governments should revise their policies to more rapidly reduce the use of low-value health interventions.

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Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Productivity Commission (2017)	To suggest innovative ways to improve outcomes through introducing the principles of competition and informed user choice whilst maintaining or improving quality of service.	Complexity in the human services delivery arises from differences in the characteristics of the services, of the individuals receiving the services, the objectives sought, and the jurisdiction and market in which services are supplied. Service delivery which is inefficient and/or ineffective can result in significant costs to the economy and individuals, including poorer outcomes and reduced productivity. Inefficiencies and ineffectiveness is being exacerbated by increased demand for services due to an ageing population, the effect of technology and costs associated with new and more complex service provision demands.	Public hearings and submissions, release of issues papers, and, inclusion of findings from international experiences and case studies. Two stages; • Release of initial study report identifying services within human services sector best suited to the introduction of greater competition, contestability and user choice. • Following a more extensive examination release of an inquiry report making recommendations on how to introduce greater competition, contestability and user choice to the services which were identified above.	Reform could offer the greatest improvements in outcomes for people who use social housing, public hospitals, specialist palliative care, public dental services, services in remote Indigenous communities, and grant-based family and community services. Government stewardship is critical. This includes ensuring human services meet standards of quality, suitability and accessibility, giving people the support they need to make choices, ensuring that appropriate consumer safeguards are in place, and encouraging adopting ongoing improvements to service provision. High quality data is central to improving effectiveness of human services.

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Medicare Benefits Schedule (MBS) Review (2015-ongoing)	To ensure affordable and universal access to best practice health services and value for both the individual patient and the health system. *However, the review did not consider;* • Division of responsibilities between governments, as this was being considered by the federation reform process • Innovative funding models for people with chronic and complex conditions, as this was being considered by PHCAG	A growing rate of low value interventions (in the MBS) and a lack of multidisciplinary care is exacerbating adverse health outcomes from chronic disease.	• Clinician lead taskforce • Stakeholder forums • Development and release of consultation paper • Public consultations, and • Release of interim report	
Private Health Insurance Consultations (2015-2016)	To consider how to encourage increased efficiency of private health insurance, enhanced value of private health insurance to consumers, increased effectiveness of Government incentives and improved financial sustainability of the private health sector.	The financial sustainability of private health insurance is threatened by the growth of chronic disease, increasing patient expectations about access to services, the number and range of health services provided, increasing costs of those services and an ageing population.	• Online consumer survey • Public submissions • Industry round tables, and • Release of issue paper	There is a need to improve transparency of information for consumers, decrease policy complexity, reduce exclusionary products that provide no value and improve effectiveness of Government incentives.

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Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
2015 Intergenerational Report – Australia in 2055, The Commonwealth of Australia, Department of Treasury (2015)	To assess the long-term sustainability of current Government policies and how changes to Australia's population size and age profile may impact economic growth, workforce and public finances over the following 40 years.	The Australian Government real health expenditure is projected to more than double over the next 40 years, from 4.2% of GDP to 5.5% of GDP in 2054-55, which means health spending per person will more than double from around $2,800 per person to $6,500 per person. If no changes to current policy are made it is on track to reach 7.1% of GDP in 2054-55. The increase in cost is being driven by higher incomes, health sector wages growth, technological change and increasing consumer expectations more than the needs of an ageing population or demographic change. The area of largest growth is Medicare services, projected to increase by over 15% per person in real terms over the next decade.		Not only will Australians live longer, but improvements in health meant they are more likely to remain active for longer. 'Active ageing' presents great opportunities for older Australians to keep participating in the workforce and community for longer, and to look forward to more active and engaged retirement years.

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Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015)	To consider reform options to shift from a fragmented and siloed system to a more integrated system, especially for people living with chronic and complex conditions. Areas for possible reform included; 1. Primary and acute interface, including the proposed and potential role of Primary Health Networks (PHNs) 2. Innovative care models for target groups such as those with complex, chronic disease 3. Funding models that best support proposed service improvements 4. Potential revised roles for existing players in the health system 5. Better recognition of mental illness	The growth in chronic and complex conditions is affecting the performance of primary health care system and subsequent integration with tertiary services. This adversely affects the quality and safety of health care delivery, especially for at risk groups.	• Public briefings • Stakeholders consultations • Sector briefings • Consumer and carer focus groups • Online survey and written submissions, and • Public webcast *PHCAG was supported by the Commonwealth Department of Health during the review process.*	Appropriate and effective care can be increased by targeting service delivery in accordance with need, establishing Health Care Homes, increasing patient engagement in care and establishing effective mechanisms to support flexible team based care. Health system integration and improvement can be enhanced by focusing on regional planning, maximising the effectiveness of private health insurance investment in the management of chronic conditions, better coordinating care and supporting cultural change across the health system. To do so, payment mechanisms to support a primary health care system must be created. This includes restructuring the payment system, pursuing opportunities for joint and pooled funding and ensuring patients contribute to their health care costs to the extent that they are able. Finally, it is necessary to measure the achievement of outcomes to support a quality and continually improving primary health care system. This includes establishing a national minimum data set (NMDS) for patients with chronic and complex conditions, new performance reporting arrangements and integrating evaluation throughout implementation of reforms.

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015) (continued)				*The PHCAG also identified the following implementation considerations;* 1. *There are many elements of the existing health care system that already provide a solid foundation from which to establish the proposed model of care.* 2. *There is a need to work within available resources. However, policy makers cannot rule out requirement for additional resources to support the model.* 3. *There is a need for early and ongoing communication and engagement with governments, PHNs, LHNs, provider organisations, and PHI and consumers.*

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Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Efficiency in Health, Productivity Commission, 2015	To identify and assess opportunities to improve the operation of Australia's health care system, without changing existing institutional and funding structures – that is, all recommendations must be 'within system'. To alleviate pressure associated with growth in expenditure there is a need to improve the quality of health services and at the same time expand access, or reduce costs, for a given level of funding.	Growth of Australian health expenditure – through taxes, insurance premiums and direct payments – is exacerbated by inefficiencies, including wasteful spending, reduced access to primary health care that results in hospital care, and substandard safety outcomes.	• Background research • Roundtable with health policy experts	To promote clinically and cost effective medicine the duplication, fragmentation and poor transparency currently detracting from efficiency of Health Technology Assessment (HTA) must be addressed. There is a need to establish expert panels of clinicians to asses and endorse guidelines, and to advise on dissemination, implementation and review of service delivery. Health system regulations must be improved, including amending scope of practice for health professionals, removing pharmacy ownership restrictions while targeting safety and access objectives more directly, eliminating delays in Pharmaceutical Benefits Scheme (PBS) price disclosure processes, identifying ways to apply a larger statutory price reduction to PBS items upon listing of a generic alternative, and examining the case for a stature independent PBS price-setting authority. The objectives and performance of private health insurance regulations need to be examined, ideally as part of a comprehensive and independent review of the Australian health care system.

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Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Efficiency in Health, Productivity Commission, 2015 (continued)	*The commission acknowledged that larger-scale reforms, informed by a comprehensive and independent review of the health system, could potentially achieve more substantive efficiency gains.*			Finally, information transparency must be enhanced, including publishing more information on the performance of individual health care facilities and clinicians, and allow researches greater access to government-held datasets. *The Commission recommended a comprehensive review to address systemic problems in the health system, including both institutional and funding structures which compromise system performance.* • *Improve and better align financial incentives with policy objectives across the health care system* • *Consider preventative health options* The Commission suggested a number of reasons why previous reform attempts havefailed, including diffuse responsibility, inadequate design and implementation, poor resourcing, and absence of political will.

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Contributing lives, thriving communities, National Mental Health Commission, (2014)	1. To consider the efficiency and effectiveness of Commonwealth services and programs and overall investment and spending patterns; 2. The efficacy and cost-effectiveness of programs, services and treatments; 3. Duplication in current services and programs; 4. The role of factors relevant to the experience of a contributing life such as employment, accommodation and social connectedness (without evaluating programs except where they have mental health as their principal focus); 5. The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programs and services;	The mental health system is poorly planned and integrated, affecting people's wellbeing and participation, Australia's productivity and economic growth.	Commissioned reviews Public submissions *Built on the work of the Commission in its first two years which were spent consulting extensively and building evidence.*	There are high-level principles to enable system change; 1. A person-centred approach 2. A new, population-based system architecture; and 3. A shift in funding to 'upstream' services and support (i.e population health, prevention, early intervention, recovery and participation) The review provided nine strategic themes intended to guide an implementation framework of activity over the next decade; 1. Set clear Government roles and accountabilities 2. Agree and implement national targets and local organisational performance measures 3. Shift funding priorities from hospitals and income support to community and primary health care services 4. Empower and support self-care and implement a new model (coordinated and integrated and redesign professional roles (pharmacist) with renewed focus on GP) of stepped care across Australia

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Contributing lives, thriving communities, National Mental Health Commission, (2014) (continued)	6. Funding priorities in mental health and gaps in services and programs, in the context of the current fiscal circumstances facing governments; 7. Existing and alternative approaches to supporting and funding mental health care; 8. Mental health research, workforce development and training; 9. Specific challenges for regional, rural and remote Australia; 10. Specific challenges for Aboriginal and Torres Strait Islander people; and 11. Transparency and accountability for outcomes of investment.			5. Promote the wellbeing and mental health of the Australian community 6. Expand dedicated mental health and social an emotional wellbeing teams for ATSI people 7. Reduce suicides and suicide attempts 8. Build workforce and research capacity to support systems change 9. Improve access to service and support through innovative technologies

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Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Review of Medicare Locals, Horvarth Review (2014)	To determine if Medicare Locals were achieving the goal of becoming effective coordinators of primary health care development and service delivery, with a specific attention on performance metrics, governance arrangements, the role of general practice in primary care, the relationship between administrative and clinical functions, regional integration, market failure and tendering or contracting arrangements.	An extension in life expectancy and growth of chronic disease – including multi-chronicity – is creating funding and capacity pressures leading to growing inequities in health outcomes. There are also unwarranted variations in clinical practice between clinicians, services and geographic locations	• Independent financial assessment • Stakeholder submissions, and • Key stakeholder interviews	The review had 5 key findings; 1. Patient outcomes can be improved by an organisation that reduces fragmentation of care 2. The role of general practice is paramount 3. A clear vision and purpose is a critical success factor 4. Clear performance expectations would enhance efficiency and effectiveness. There is also scope to enhance administrative efficiency by consolidating all corporate, financial and administrative functions. 5. Efficiently administrated local health organisations could leverage its role as a facilitator and purchaser of care.

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Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Reform of Federation, Issues Paper 3, Health (2014)	To clarify roles and responsibilities between levels of government to reduce and end the duplication and second guessing between different levels of government, achieve a more efficient and effective federation, and in doing so, improve national productivity. Ultimately, to ensure the federal system is better understood and valued by Australians, has clearer roles and responsibilities, enhances governments	The complex split of government roles means no single level of government has all the policy levers needed to ensure a cohesive system. This affects patients with chronic and complex conditions – who move from one health service to another – and creates a challenge of providing better integrated and coordinated care. The pressure on current health care arrangements services driven by external pressures of ageing population, more expensive technology, growing rates of chronic disease, and increasing consumer expectations.	• Taskforce established by the Department of Prime Minister and Cabinet (DPMC) • Process was an item on the Council Of Australian Governments (COAG) agenda • Consultation with business, non-government experts and the community, and • The Prime Minister Business Advisory Council also played a key part in providing advice.	Better governance conditions would improve service coordination within and across systems, address service gaps, reduce inefficiencies, and ultimately improve outcomes. They also recognized that a lack of accountability had been addressed by previous reviews. As the NHHRC found in 2009, a 'lack of clarity of accountability and definition of responsibilities creates the environment for a blame game, as each government is able to blame the other for shortcomings attributed to each other's programs'. In addition, the NCOA found the complex arrangements between Commonwealth and States and Territories for public hospitals result in 'a lack of clarity when it comes to political responsibility and accountability'. The current arrangements make it difficult for the public to know who to hold accountable for policy successand failures.

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Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Reform of Federation, Issues Paper 3, Health (2014) (continued)	autonomy, flexibility and political accountability and supports Australia's economic growth and international competitiveness. *The not-for-profit and private sectors have significant roles in health care, particularly in service delivery – however, the focus on the White Paper is on government roles and responsibilities.*			A lack of a health 'system' is perhaps best illustrated when considering Governments role in mental health. The range of services people need extends beyond 'health care' to housing, employment and social participation. Ultimately, there is no mental health 'system' because; 1. Services are poorly integrated, overseen by different parts of government, based on widely different organising principles that are not working towards a common goal. 2. Cross-portfolio interactions are particularly complex when applied to mental health. For example, disability, income support and employment services are all Commonwealth responsibilities and yet States incur costs if people need care in public hospital, interact with the justice system, or become homeless. 3. No level of government 'owns' mental health, which inturn has made it difficult to ensure accountability for mental health outcomes.

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National Commission of Audit – Towards Responsible Government (2013)	To find efficiency and productivity improvements across all areas of Commonwealth expenditure, and to return the budget to a sustainable surplus of 1% of GDP by 2023-24	The growth in health expenditure is unsustainable and due to costly and ineffective duplication of service delivery, an absence of proper program evaluation on Commonwealth programs, a lack of subsidiarity and both horizontal and vertical fiscal imbalance.	Public submissions	The Commission released recommendations in two phases and ultimately suggested that more deregulated and competitive markets, with appropriate safeguards, have the greatest potential to improve the health sectors competitiveness and productivity. Further, the community must become aware of the 'real costs of health care'. As such those on higher incomes need to take greater responsibility for their own health care costs and everyone must make a small contribution to the cost of their own health care; 1. Higher-income earners should take out private health insurance for basic health services in place of Medicare To improve the effectiveness of private health insurance arrangements the Government should consider; 1. Broadening PHI into primary care 2. Relaxing of 'improper discrimination' and allowing health funds to vary premiums for a limited number of lifestyle factors. 3. Aim to move to a prospective risk-equalisation

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Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
National Commission of Audit – Towards Responsible Government (2013) (continued)				To improve the effectiveness of Medicare government should; 1. Review the Extended Medicare Safety Net 2. Review Medicare Schedule against contemporary evidence of safety, clinical effectiveness and cost effectiveness. 3. Co-payments for Medicare Benefits Schedule and Pharmaceutical Benefits Scheme There is a need to improve public hospital funding arrangements with the states including the unnecessarily complex and inefficient National Health Agreement process. Further, attention is rationing of agencies and development of others, as well as reforming scope of professional practice. *Finally, there is a need for detailed work to delve more deeply into restructuring the health system. This recognises both the complexity and the need to progress reform carefully, either through major structural reform or incremental change.*

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Building a 21st Century Primary Health Care System, Department of Health and Ageing (2010) **Informed by Primary Health Care Reform in Australia, Report to Support Australia's First National Primary Health Care Strategy**	To provide the platform on which to build an effective and efficient primary health care system and provide a roadmap to guide current and future policy, planning and practice in the Australian primary health care sector. *The 2008 National Health Agreement recognised that primary health care involves Commonwealth and state/ territory responsibilities but depends on the significant role of private providers and community organisation. This strategy comes at a time when Australian Government is building the National Health and Hospital Network (following NHHRC), including taking full funding and policy responsibility for primary health care services in Australia.*	The health system faces significant challenges due to a growing burden of chronic disease, an ageing population, workforce pressures, unacceptable inequities in health outcome and access to services. Primary care operates as a disparate set of services rather than an integrated service system and cannot respond effectively to changing pressures (demographic, burden of disease, emerging technologies, changing clinical practice) or coordinate care within and across various elements of the broader health system	• Public submissions • Development and release of discussion paper • Forums with representatives from state and territory health departments • Supported by External Reference Group (ERG) *Undertaken alongside complementary health reform processes including NHHRC and NPHT*	Five key building blocks were identified to create a strong, responsive and cost-effective primary health care system including; regional integration; information and technology, including eHealth, investing in a skilled workforce, infrastructure and financing and system performance The four key priority areas for change were; 1.Improving access and reducing inequity 2. Better management of chronic conditions 3. Increasing the focus on prevention 4. Improving quality, safety, performance and accountability *Transferring funding and policy responsibility to the Australian Government aims to improve services in the community, address gaps in access and drive diversity and innovation in service delivery.*

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Healthier Future for All Australians, National Health and Hospital Reform Commission (2009)	To provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term to; 1. Reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing 2. Better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health 3. Bring a greater focus on prevention to the health system 4. Better integrated acute services and aged care services, and improve the transition between hospital and aged care	The NHHRC identified the following challenges; 1. Access to services – large increases in demand for and expenditure on health care 2. Growing burden of chronic disease 3. Population ageing 4. Costs and inefficiencies generated by blame game and cost shifting 5. Escalating costs of new health technologies 6. Unacceptable inequities in health outcomes and access to services and growing concerns about safety and quality 7. Workforce shortages	• Public submissions and consultations • Commissioned discussions papers • Produced a background paper, and • Released an interim report – Healthier Future for all Australians – and called for submissions and survey responses.	The NHHRC delivered 123 recommendations, grouped in four reform themes; 1. *Taking responsibility:* encouraging and supporting greater individual and collective action to build good health and wellbeing, by individuals, families, communities, health professionals, employers, health funders and governments. 2. *Connecting care:* delivering comprehensive care for people over their lifetime, nurturing a health start, ensuring timely access and safe care in hospitals, restoring people to better health and independent living, increasing choice in aged care, caring for people at the end of life 3. *Facing inequities:* taking action to tackle the causes and impact of health inequities, closing the health gap for ATSI, delivering better health outcomes for remote and rural communities, supporting people living with mental illness and improving oral health and access to dental care

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Healthier Future for All Australians, National Health and Hospital Reform Commission (2009) (continued)	5. Improve provision of health services in rural areas 6. Improve Indigenous health outcomes 7. Provide a well-qualified and sustainable health workforce into the future	Particular emphasis was placed on the fact the fragmented system – complex division of funding responsibilities and performance accountabilities between different levels of government – is ill-equipped to respond to these challenges.		4. *Driving quality performance:* having leadership and systems to achieve the best use of people, resources and knowledge, strengthening the governance of health care, raising and spending money for health services, a sustainable workforce for the future, fostering continuous learning in the health system, implementing a national e-health system.

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Australia: The Healthiest Country By 2020, National Preventative Health Taskforce (2009)	Established to develop a strategy (focusing initially on obesity, tobacco and excessive consumption of alcohol) of primary prevention in both health and non-health sectors to prevent Australians dying prematurely.	The overall cost to the healthcare system associated with these three risk factors is in the order of almost $6billion per year, while lost productivity is estimated to be almost $13 billion. The impending overload of the health and hospital system will decrease the productivity – and therefore competitiveness – of Australia's workforce.		The strategy has key strategic actions areas in obesity, tobacco and alcohol. Some required new human and financial resources, some of them require enhanced regulation or legislation, while others require further evidence for progress. Many need to be scaled up at sufficient intensity, scope and duration to have a tangible effect. Strategy had seven strategic directions, including shared responsibility – developing strategic partnerships, acting early and throughout life, engaging communities, influencing markets and develop coherent policies, reducing inequity, contributing to 'Close the Gap', refocusing primary healthcare towards prevention. Ambitious targets included; • Halt and reverse the rise in overweight and obesity • Reduce the prevalence of daily smoking to 10% or less • Reduce the proportion of Australians who drinks at short-term risky/high-risk levels to 14%, and the proportion of Australians who drink at long-term risky/high-risk levels to 7% • Contribute to the 'Close the Gap' target for Indigenous people, reducing the life expectancy

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Australia: The Healthiest Country By 2020, National Preventative Health Taskforce (2009) (continued)				Recommended a new national capacity will be developed through COAG National Prevention Partnership and National Prevention Agency (NPA) – facilitate national prevention research infrastructure
Intergenerational Report 2002-03, The Commonwealth of Australia, Department of Treasury (2002)	To assess the long-term sustainability of current Government policies and how changes to Australia's population size and age profile may impact economic growth, workforce and public finances over the 40 years. Key priorities for ensuring fiscal sustainability should be; 1. Maintaining an efficient and effective medical health system, complemented by widespread participation in private health insurance	Over the past three decades, Commonwealth health spending has more than doubled, to 4.0% of GDP in 2001-02. Less than 20% is funded through the Medicare Levy. The PBS has been the fastest growing component. Most of growth comes from the demand for new technology and treatments. Australians expect to access more expensive diagnostic procedures and medications. Non-demographic factors are likely to generate the greatest cost pressures in the future. Technological change accounts for a significant proportion		Ongoing sound management of the PBS will be required to keep long-term growth in the scheme sustainable, to allow governments to continuing providing access to affordable medicines for all Australians.

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
	2. Containing growth in the Pharmaceutical Benefits Scheme (PBS) 3. Developing an affordable and effective residential aged care system that can accommodate the expected high growth in the number of very old people (people aged 85 or over)	of non-demographic growth in health spending per person. As the Commonwealth exercises significant controls over whether to adopt new technology in the health system, past increases in spending partly reflect the Commonwealth's choice to fund new technology. Growth has occurred even though policies aimed to constrain costs while improving the quality of health care have occurred Population growth and ageing have contributed 1/3rd of the recent growth. Steadily ageing population is likely to continue to place significant pressure on Commonwealth government finances. In addition, on the basis of recent trends it seems likely that technological advancement, particularly in health care, and the community expectation of accessing the latest health treatments will continue to place increased demands on taxpayers' fund.		

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Private Health Insurance, Industry Commission (1997)	Recent initiatives to alleviate budgetary pressures were intended to stem decline of private health insurance – both regulatory changes and financial inducements – however, premiums have continued to increasing raising community concerns that have led to this inquiry. The commission was mainly required to determine why premiums were increasing, and to suggest remedies. *Importantly, terms of reference explicitly blocked a wider examination of the health system.*	The Australian health system is a 'mixed' system, where PHI provides top-up funding for additional services and amenities, as well as displacing the need for public funding for services available under Medicare. Challenges that arise from this mixed system include rapidly rising premiums for private health insurance, the decreased affordability of private health insurance, falling membership, growing demand on the public system as the 'safety valve' function for public system is deteriorating.	• Visits and discussions with organisations and individuals • Releases of issues paper • Roundtable discussion • Public submissions • Release of discussion draft with further public submissions	Had 22 recommendations, and ultimately suggested risk rating provided the only way funds could efficiently manage insurance. Community rating, dating to pre-Medicare, was a hindrance to more efficient competition and lower prices. Noted that the system suffered from an 'inherent tension between policies of universal access to a "free" public system and community rating for private health insurance'. Also stated 'it has become apparent from this inquiry that it is impossible to define the most appropriate role of private health insurance without determining how the bigger system is intended to function.' Suggested a broad public inquiry into Australia's health system, encompassing; 1. Health financing, including state/federal cost shifting incentives 2. Integrated health systems and coordinated care 3. The role of copayments 4. Competitive neutrality between players in the system 5. Market power exerted by players in the system, including supply constraints in the medical market 6. Community rating, including assessment of pre-existing ailment rules

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Private Health Insurance, Industry Commission (1997) (continued)				7. Information management in health care 8. Progress of protocol development If unmanageable, a number of specific inquiries could be undertaken, focusing on themes such as financing issues, quality of health care, and competitive neutrality. (as such, still to happen)

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Looking Forward to Better Health, Better Health Commission (1987)	To inquire into the current health status of the Australian population and recommend national health goals, priorities and programs to achieve significant improvements in illness prevention and health awareness. The commission was asked to consider the special needs of a number of specific groups including ATSI, people with disabilities, immigrants, older people, women and youth.	The challenges facing the health system include no national focus on illness prevention, no national directions, strategies, objectives or goals, medical schools are failing to train students to promote health, research into illness prevention is fragment and sparse, national funding for illness prevention is small and erratic and information and skills sharing is limited. Much of health care planning and policy has up until this point concerned itself with how doctors are paid, how hospitals are funded, and how medicines are financed. Attention is now needed on how to prevent ill-health.	• Written submissions • Public hearings • Workshops • Study groups seminars • Interim report released and written responses	Identified six priority policy areas – cardiovascular disease, nutrition, cancer, communicable diseases and mental health with the following action areas; 1. Involvement of children at school 2. Training of professionals in prevention at universities and colleges 3. Provision of incentives to health professionals to promote prevention 4. Role of the media, both positive and negative, in prevention 5. Role of research and evaluation

Appendix 1: Reviews reviewed

Review name (year)	Review focus areas	Summary of health system challenges	Method of review	Key findings and/or recommendations
Hospital and Health Services Commission The Commonwealth of Australia (1973)	To recommend on the provision of health services by the Department of Health. The commission was asked to ascertain health care needs and to make recommendations concerning; 1. Health care delivery systems 2. Funds to be allocated for these systems 3. The education of health personnel 4. The accreditation of services 5. Financial assistance to be made available to States, Territories, region, local governments, charitable organisations and persons	'Health is a community affair', and as such, is necessary to address the lack of community-based health services and preventative health programs. Also noted inequities in access to health services, especially among aboriginal Australians and people living in rural or remote Australia.	• Devised a strategy for 'a judicious blend of study and action' • Established working parties, standing committees and advisory committees • Produced discussion papers and final reports • Implemented programmes on approval of the Minister for Health	Provided recommendations guided by the 'Primary Health Care' model; 1. Need to strengthen comprehensive health care 2. Placed an emphasis on continuing care of persons 3. Health system should be strong and reliable 4. Maintained that personal health care remains a personal responsibility to a considerable extent Highlighted long neglected areas, including aboriginal health, occupational health, public health, rural health and health transport which require further attention, emphasised planning and evaluation of health services and recommended existence of a separate Health Insurance Commission for 'Medibank', later 'Medicare'.

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers healthworkforce, medical products, technologies, information & research
Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017)	The review did not consider the division of responsibilities between governments, as this was being considered by the Federation reform process (see Reform of Federation, Issue Paper, below).	Implement nimble funding arrangements at the regional level: The Australian, State and Territory Governments should allocate (modest) funding pools to Primary Health Networks and Local Hospital Networks for improving population health, managing chronic conditions and reducing hospitalisations at the regional level.	Make the patient the centre of care: All Australian governments should re-configure the health care system around the principles of patient-centred care, with this implemented within a five year timeframe.	Disseminate best practice to health professionals, principally through the various medical colleges, the Australian Commission on Safety and Quality in Health Care and similar state-based bodies.	Information transparency: Collect and divulge data at the hospital and clinician level for episodes of care that lead to hospital-acquired complications and for interventions that have ambiguous clinical impacts (such as knee arthroscopies).
Introducing Competition and Informed User Choice into Human Services Identifying Sectors for Reform, Productivity Commission (2017)			Recommended introducing the principles of competition and informed user choice in public hospitals, specialist palliative care and public dental services are needed to address inefficiencies and ineffectiveness.		Strong focus on providing healthcare consumers with more information on available services to enable consumer-directed care.

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers health workforce, medical products, technologies, information & research
Medicare Benefits Schedule (MBS) Review (2015-ongoing)	The review did not consider the division of responsibilities between governments, as this was being considered by the Federation reform process (see Reform of Federation, Issue Paper, below).	The review did not consider innovative funding models for people with chronic and complex conditions, as this was being considered by PHCAG (See Better Outcomes for People with Chronic and Complex Conditions, below).	Recommended a renewed focus on multidisciplinary care is needed.	The review is working through the identification of low value interventions (in the MBS) exacerbating adverse health outcomes, which are being released in tranches.	
Commonwealth Government Response to ongoing MBS Review		As of April 2018, the Commonwealth had accepted over 80 MBS Review Taskforce recommendations, aimed at ensuring MBS items are best practice and evidence-based. This has included the removal of obsolete items and the modification of many others that were considered low or no value and/or were not evidence based.		Removal of obsolete items and the modification of many others that were not in line with current best practice.	

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers health workforce, medical products, technologies, information & research
Private Health Insurance Consultations (2015-2016)		Recommended that there is a need to reduce exclusionary products that provide no value and improve effectiveness of Government incentives.			Recommended that there is a need to improve transparency of information for consumers.
Commonwealth Government Response; establishment of the Private Health Ministerial Advisory Committee (PHMAC) in 2016 and introduction of Private Health Insurance reforms in 2017		The 2017 PHI reforms were developed in line with PHMAC recommendations, they include: 1. Allowing insurers to expand hospital insurance to offer travel and accommodation benefits for people in regional and rural areas that need to travel for treatment 2. Requiring insurers to allow people with hospital insurance that does not offer full cover for mental health treatment to upgrade their cover and access mental health services without a waiting period on a once-off basis		3. Removing coverage for a range of natural therapies as benefits under general treatment	4. Developing easy to understand categories of private health insurance. 5. Upgrading the privatehealth.gov.au website to make it easier to compare insurance products. 6. Boosting the powers of the Private Health Insurance Ombudsman and increasing its resources to ensure consumer complaints are resolved clearly and quickly

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers health workforce, medical products, technologies, information & research
Commonwealth Government Response; establishment of the Private Health Ministerial Advisory Committee (PHMAC) in 2016 and introduction of Private Health Insurance reforms in 2017 (continued)		1. Increasing the maximum excess consumers can choose under their health insurance policies for the first time since 2001.			2. Reducing costs for consumers through a $1.1 billion reduction in prostheses benefits under an agreement with the Medical Technology Association of Australia
Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015)-		1. Maximise the effectiveness of private health insurance investment in the management of chronic conditions 2. Restructure the payment system to support the HCH model 3. Pursue opportunities for joint and pooled funding between PHNs, LHNs, and the Commonwealth, State and Territory governments.	1. Better targeting of services for patients with chronic and complex conditions in accordance with need. 2. Establish Health Care Homes. 3. Activate patients to be engaged in their care.	1. Support a quality and continually improving primary health care system 2. Establish new performance reporting arrangements	1. Establish effective mechanisms to support flexible team based care 2 Support cultural change across the health system via education and training to health professionals and consumers related to the HCH model 3. Establish a national minimum data set (NMDS) for patients with chronic and complex conditions

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers health workforce, medical products, technologies, information & research
Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015)-(continued)		4. Patients continue to contribute to their healthcare costs to the extent that they are able.	4. Require PHNs to collaborate with LHNs, PHIs, providers and patients to support regional planning, including the establishment of locally relevant patient health care pathways and admission and discharge protocols. 5. Coordinate care across the health system to improve patient experience		4. Integrate evaluation throughout implementation of the HCH model.

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers health workforce, medical products, technologies, information & research
The Commonwealth Government accepted the 15 key recommendations from the PHCAG, beginning the staged implementation of the Health Care Home Model (March 2016)	The Government response aims to create greater co-ordination between Primary Health Care Networks (PHNs) and Local Hospital Networks (LHNs) in the planning and procurement of health services for their local communities. In addition, a Health Care Home implementation advisory group to oversee the design, implementation and evaluation of the trials ahead of the national rollout.	Payments for Health Care Homes will be bundled together into regular quarterly payments. This will encourage providers to be flexible and innovative in how they communicate and deliver care, and will ensure that the patients' health care needs are regularly monitored and reviewed. This is a move away from current fee-for-services model for these eligible patients, except where a routine health issue does not relate to their chronic illness.	The establishment of Health Care Homes, which will co-ordinate all of the medical, allied health and out-of-hospital services required as part of a patient's tailored care plan. Health Care Homes will be delivered by GP practices or Aboriginal Medical Services. Patients will be able to enrol with the Home of their choice. A risk stratification tool to determine an individual patient's eligibility for new packages will be developed.	The response includes an improved use of digital health measures to improve patient access and efficiency, including the new MyHealth Record, telehealth and teleweb services, remote health monitoring and medication management technologies. The creation of a National Minimum Data Set of de-identified information to help measure and benchmark	The response includes; 1. Tailored patient care plans developed in partnership with patients and their families. 2. Stronger data collection, measurement and evaluation tools to allow a patient's individual progress to be measured and their care plan to be better tailored to their needs. 3. Processes to empower patients and their families to be partners in their own care and take greater responsibility for the management of their conditions.

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
The Commonwealth Government accepted the 15 key recommendations from the PHCAG, beginning the staged implementation of the Health Care Home Model (March 2016) (continued)				primary health care performance at a local, regional and national level to inform policy and help identify regionally-specific issues and areas for improvement.	

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Efficiency in Health, Productivity Commission, 2015	The review accepted the ToRsthat mandated policy recommendations should be implemented without changing existing institutional and funding structures – that is, all recommendations must be 'within system'. However, the Commission recommended a comprehensive review to address systemic problems in the health system, including both institutional and funding structures which compromise system performance. This review would improve and better	Commission a review of the objectives and performance of private health insurance regulations (ideally as part of a comprehensive and independent review of the Australian health care system) to increase involvement of private health insurers in preventive health and coordinated care.	Recommended that to promote clinically and cost effective medicine the duplication, fragmentation and poor transparency currently detracting from efficiency of Health Technology Assessment (HTA) must be addressed. There is a need to establish expert panels of clinicians to asses and endorse guidelines, and to advise on dissemination, implementation and review of service delivery. Health system regulations including; 1. amending scope of practice for health professionals	Publish more information on the performance of individual health care facilities and clinicians as a meansto improve safety and quality.	Recommendedthat there is a need to enhance information transparency, including publishing more information on the performance of individual health care facilities and clinicians, and allow researches greater access to government-held datasets.

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Efficiency in Health, Productivity Commission, 2015 (continued)	align financial incentives with policy objectives acrossthe health care system and better achieve preventative health options. Further, the objectives and performance of private health insurance regulations need to be examined, ideally as part of a comprehensive and independent review of the Australian health care system.		2. removing pharmacy ownership restrictions while targeting safety and access objectives 3. more directly, eliminating delays in Pharmaceutical Benefits Scheme (PBS) price disclosure processes 4. identifying ways to apply a larger statutory price reduction to PBS items upon listing of a generic alternative 5. and, examining the casefor a statutory independent PBS price-setting authority.		

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers health workforce, medical products, technologies, information & research
Commonwealth Government response to Productivity Commission, Efficiency in Health	Developed the PHCAG to gain more evidence on the clinical and cost effectiveness of specific preventive health measures.	Initiated the Private Health Insurance Consultations to review the benefits in amending restrictions – limiting the ability of insurers to develop new and innovative products that better meet customer needs – to enable insurers to play a greater role in supporting better health outcomes and lowering health care costs.	Some state and territory governments have begun initiating and evaluations trials of changing regulation of health professionals to expand workforce scope of practice.	Initiated steps (MBS Review) to reduce wasteful spending through subsidised medicines and health services, and accepted the recommendation to involve clinicians in guideline development and implementation through clinician expert panels.	

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers health workforce, medical products, technologies, information & research
Contributing lives, thriving communities, National Mental Health Commission, (2014)	Recommended setting clear Government roles and accountabilities	Recommended a shift in funding to 'upstream' services and support (i.e. population health, prevention, early intervention, recovery and participation), and a shift in priorities from hospitals and income support to community and primary health care services via pooled funding.	Proposed a new, population-based system architecture to implement a new model (coordinated and integrated and redesign professional roles (pharmacist) with renewed focus on GP) of stepped care across Australia, and expand dedicated mental health and social an emotional wellbeing teams for ATSI people.	Recommended that there is need to agree and implement national targets and local organisational performance measures, and improve access to service and support through innovative technologies.	Proposed a person-centred approach that empowers and supports self-care.

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers health workforce, medical products, technologies, information & research
Australian Government Response to the Commission's mental health review (2015)	Accepted review recommendations, and proposed the planning and commission of mental health services would occur through Primary Health Networks (PHNs) and the establishment of a flexible primary mental health care funding pool. In addition, suggested national leadership in mental health reform, through the development of the Fifth National Mental Health Plan.	The PHN flexible pool will support; 1. provision of services through stepped care model 2. a commission of youth mental health services based on community need, such as; 3. a single integrated end to end school based mental health program 4. new pathways to services including online based support	Government response included: 1. Improving services and coordination of care for people with severe and complex mental illness. 2. Refocusing primary mental health care programs and services to support a stepped care model. 3. Joined up support for child mental health, and an integrated and equitable approach to youth mental health.		Response included proposing a new digital mental health gateway, offering phone line and online access to navigate mental health services as a first line of support. Consumers will have straightforward access to evidence based information, advice and digital mental health treatment.

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Australian Government Response to the Commission's mentalhealthreview (2015) (continued)			4. Integrating Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing services.		
Review of Medicare Locals (2014)	Recommended that a clear vision and purpose is a critical success factor and there is also scope to enhance administrative efficiency by consolidating all corporate, financial and administrative functions.	Recommendedthat efficiently administrated local health organisations could leverage its role as a facilitator and purchaser of care.	Recommendedthat patient outcomes can be improved by an organisation that reduces fragmentation of care, and that the role of general practice is paramount.	Recommended that clear performance expectations would enhance efficiency and effectiveness.	

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Commonwealth Government response to Horvath review(July2015)	The Australian Government accepted the recommendations in the Horvath review, and established 31 new Primary Health Networks (PHNs) – worth a total of nearly $900 million – which are 'outcome focused' on improving frontline services.		In addition to general health, the Commonwealth Government set PHNs six key priorities for targeted work in mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.		

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Commonwealth Government response to Horvath review (July 2015) (continued)	The two main objectives are to 'increase the efficiency and effectiveness of medical services for those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time' PHNs are independent organisations aligned with those of the state and territory Local Health Networks (LHNs) or equivalent. They have skills-based boards informed by clinical councils and community advisory committees.				

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Reform of Federation, Issues Paper 3, Health (2014) **Following consideration of federation reform at the Council of Australian Governments meeting on 1 April 2016, work to improvefederal financial relations and the transparency of government spending will be progressed by the Council on Federal Financial Relations, and Commonwealth, State and Territory Treasuries.*	Recommended that there is a need to clarify roles and responsibilities between levels of government to reduce and end the duplication and second guessing between different levels of government, achieve a more efficient and effective federation, and in doing so, improve national productivity. Better governance conditions would improve service coordination within and across systems, address service gaps, reduce inefficiencies, and ultimately improve outcomes.				

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers health workforce, medical products, technologies, information & research
National Commission of Audit – Towards Responsible Government (2013)	Recommended the rationing of agencies and development of others, as well as reforming scope of professional practice. Also recommended that *there is a need for detailed work to delve more deeply into restructuring the health system. This recognises both the complexity and the need to progress reform carefully, either through major structural reform or incremental change.*	Recommended that the growth in health expenditure is unsustainable and due to costly and ineffective duplication of service delivery, an absence of proper program evaluation on Commonwealth programs, a lack of subsidiarity and both horizontal and vertical fiscal imbalance. In additional, suggested that there is a need to improve public hospital funding arrangements with the states including the unnecessarily complex and inefficient National Health Agreement process. Recommended that to improve the effectiveness of PHI arrangements the Government should consider; • Broadening PHI into primary care • Relaxing 'improper discrimination' and allowing health funds to vary premiums for a limited number of lifestyle factors. • Aim to move to a prospective risk-equalisation	Recommended more deregulated and competitive markets, with appropriate safeguards, as they have greatest potential to improve the health sectors competitiveness and productivity.		

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers health workforce, medical products, technologies, information & research
National Commission of Audit – Towards Responsible Government (2013) (continued)		To improve the effectiveness of Medicare government should; • Review the Extended Medicare Safety Net • Review Medicare Schedule against contemporary evidence of safety, clinical effectiveness and cost effectiveness. • Co-payments for Medicare Benefits Schedule and Pharmaceutical Benefits Scheme Further, the community must become aware of the 'real costs of health care'. As such those on higher incomes need to take greater responsibility for their own health care costs and everyone must make a small contribution to the cost of their own health care. Higher-income earners should take out private health insurance for basic health services in place of Medicare			

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Commonwealth Government, Response to the National Commission of Audit Report, May 2014 The National Commission of Audit was an important input to the Government's considerations ahead of the 2014-15 Budget, and many of the policy issues raised in the NCOA were considered by the Government when preparing the 2014-15 Budget.	Structural reforms to Health, 'Recommendation 17.Short to medium term health reforms', were in the 2014-15 Budget and Further health reforms 'Recommendation 18.A pathway to reforming health care' was considered following the Budget. Regarding 'Recommendation 40. Mental Health', Mental Health reforms will were considered in the Mental Health Review (see above).	Initial structural reforms to the PBS 'Recommendation 19.PBS' were in the 2014-15 Budget, with other reforms to be considered following the Budget.			

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Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Commonwealth Government, Response to the National Commission of Audit Report, May 2014 The National Commission of Audit was an important input to the Government's considerations ahead of the 2014-15 Budget, and many of the policy issues raised in the NCOA were considered by the Government when preparing the 2014-15 Budget. (continued)	The 2014-15 Budget included the consolidation of health bodies, 'Recommendation 53.' Both 'Recommendation 57. Privatisations.' and 'Recommendation 59. Outsourcing, competitive tending and procurement' may have informed development of Productivity Commissionreview (see above)				

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Building a 21st Century Primary Health Care System, Department of Health and Ageing (2010) Informed by Primary Health Care Reform in Australia, Report to Support Australia's First National Primary Health Care Strategy	This strategy came at a time when Australian Government wasbuilding the National Health and Hospital Network (following the NHHRC), including taking full funding and policy responsibility for primary health care services in Australia. Transferring funding and policy responsibility to the Australian Government aimsto improve servicesin the community, address gaps in access and drive diversity and innovation in service delivery.	Recommended regional integrational infrastructure planning and financing would improve access and reducing inequity.	Increasethe focus on prevention in service delivery and design.	Improve quality, safety, performance and accountability frameworks.	Recommended investing in a skilled workforce and eHealth to improve system performance.

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Healthier Future for All Australians, National Health and Hospital Reform Commission (2009)	Recommended reducing inefficiencies generated by cost-shifting, blame-shifting and buck-passingthrough system reform, which would include having leadership and systemsto achieve the best use of people, resources and knowledge and strengthening the governance of health care.	Recommendations included reforms to the raising and spending of money for health services.	Recommendations included the need to; 1. Better integrate and coordinate care across all aspectsof the health sector, particularly between primary care and hospital services around key measurable outputs for health 2. Better integrated acute services and aged care services, and improve the transition between hospital and aged care 3. Bring a greater focus on prevention to the health system		1. Fostering continuous learning in the health system, implementing a national e-health system. 2. Provide a well-qualified and sustainable health workforce into the future.

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Healthier Future for All Australians, National Health and Hospital Reform Commission (2009) (continued)			4. Delivering comprehensive care for people over their lifetime – nurturing a health start, ensuring timely access and safe care in hospitals, restoring people to better health and independent living, caring for people at the end of life.		

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Australia: The Healthiest Country By 2020, National Preventative Health Taskforce (2009)	Recommended a new national capacity will be developed through COAG National Prevention Partnership and National Prevention Agency (NPA) – facilitate national prevention research infrastructure	The strategy has key strategic actions areas in obesity, tobacco and alcohol. Some required new human and financial resources, some of them require enhanced regulation or legislation, while others require further evidence for progress. Many need to be scaled up at sufficient intensity, scope and duration to have a tangible effect.			

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Intergenerational Report 2002-03, The Commonwealth of Australia, Department of Treasury (2002)		Recommendedthat key priorities for ensuring fiscal sustainability should be; 1. Maintaining an efficient and effective medical health system, complemented by widespread participation in private health insurance 2. Containing growth in the Pharmaceutical Benefits Scheme 3. Developing an affordable and effective residential aged care system that can accommodate the expected high growth in the number of very old people (people aged 85 or over) 4. Ongoing sound management of the PBS is required to keep long-term growth in the scheme sustainable, to allow governments to continuing providing access to affordable medicines for all Australians.			

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Private Health Insurance Industry Commission (1997)	The Commission recommended that 'it has become apparent from this inquiry that it is impossible to define the most appropriate role of private health insurance without determining how the bigger system is intended to function.' Suggested a broad public inquiry into Australia's health system.	The commission had 22 recommendations, and ultimately suggested risk rating provided the only way funds could efficiently manage insurance. The Commission suggested that community rating, dating to pre-Medicare, was a hindrance to more efficient competition and lower prices. It also noted that the system suffered from an 'inherent tension between policies of universal access to a "free" public system and community rating for private health insurance'.			

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablershealthworkforce, medical products, technologies, information & research
Looking Forward to Better Health, Better Health Commission (1987)			Recommended six priority policy areas – cardiovascular disease, nutrition, cancer, communicable diseases and mental health with the following action areas; • Involvement of children at school • Training of professionals in prevention at universities and colleges • Provision of incentives to health professionals to promote prevention • Role of research and evaluation		

Appendix 2: Synthesized review recommendations assessed against adapted WHO Health System Performance Components and associated Government response (where applicable)

Review name, (year) Government response on following row	Health system stewardship	Health care financing	Health services design	Quality and safety of service provision	Enablers health workforce, medical products, technologies, information & research
Hospital and Health Services Commission The Commonwealth of Australia (1973)	Emphasised planning and evaluation of health services and recommended existence of a separate Health Insurance Commission for 'Medibank', later 'Medicare'.		Provided recommendations guided by the 'Primary Health Care' model; • Recommended the need to need to strengthen comprehensive health care • Placed an emphasis on continuing care of persons • Highlighted long neglected areas, including aboriginal health, occupational health, public health, rural health and health transport which require further attention. Maintained that personal health care remains a personal responsibility to a considerable extent		

Appendix 3: Summary of review recommendations (grouped by system component/ WHO building block)

Health System Stewardship	
Recommendation	**Review or Report**
Clarify roles and responsibilities between levels of government to end duplication and improve efficiency, service coordination and health outcomes.	• Reform of Federation, Issues Paper 3, Health (2014)
First Ministers should agree to a new' Healthy Australia Accord' that clearly articulates the agreed and complementary roles and responsibilities of all governments in improving health services and outcomes for all Australians.	• Healthier Future for All Australians, National Health and Hospital Reform Commission (2009)
Set clearly defined government roles and responsibilities.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Efficiency in Health, Productivity Commission (2015) • Contributing lives, thriving communities, National Mental Health Commission
Need for detailed inquiry to delve more deeply into restructuring the health system.	• Efficiency in Health, Productivity Commission (2015) • National Commission of Audit – Towards Responsible Government (2013) • Private Health Insurance, Industry Commission (1997)
Consolidate all corporate, financial and administrative functions within the Medicare Locals (now PHNs).	• Horvath Medicare Locals Review (2014)

Health System Financing	
Implement innovative funding models (i.e. shift away from purely fee-for-service models).	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015) • Efficiency in Health, Productivity Commission (2015)
Pursue opportunities for joint and pooled funding between PHNs, LHNs, and the Commonwealth, State and Territory governments.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015) • Contributing lives, thriving communities, National Mental Health Commission (2014)
Promote regional, decentralised health planning and financing to meet the needs of local communities.	• Horvath review of Medicare Locals (2014) • Building a 21st Century Primary Health Care System, Department of Health and Ageing (2010)
Maximise the effectiveness of private health insurance contributions towards healthcare expenditure and the management of chronic conditions.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Private Health Ministerial Advisory Committee (PHMAC) recommendations (2017) • Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015) • Efficiency in Health, Productivity Commission (2015) • National Commission of Audit – Towards Responsible Government (2013) • Private Health Insurance, Industry Commission (1997)
Reform PBS price setting mechanisms to reduce expenditure (government and individual) on pharmaceuticals.	• Efficiency in Health, Productivity Commission (2015) • Intergenerational Report 2002-03, Commonwealth of Australia, Department of Treasury (2002)

Shift funding focus from hospitals to prevention primary and community care.	• Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Productivity Commission(2017) • National Commission of Audit – Towards Responsible Government (2013) • Healthier Future for All Australians, National Health and Hospital Reform Commission (2009)
Discontinue funding of MBS items that are shown to be ineffective or low value against contemporary evidence.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Medicare Benefits Schedule (MBS) Review (2015-ongoing) • National Commission of Audit – Towards Responsible Government (2013)
Co-payments for MBS and PBS items.	• National Commission of Audit – Towards Responsible Government (2013)
Health Services Delivery/ Design	
Increased focus on prevention.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Healthier Future for All Australians, National Health and Hospital Reform Commission (2009) • Building a 21st Century Primary Health Care System, Department of Health and Ageing (2010) • Australia: The Healthiest Country By 2020, National Preventative Health Taskforce (2009) • Looking Forward to Better Health, Better Health Commission (1987)
Focus on out-of-hospital care to improve fragmentation and coordination.	• Horvath review of Medicare locals (2014) • Hospital and Health Services Commission, The Commonwealth of Australia (1973)
More deregulated and competitive markets, with appropriate safeguards, as they have greatest potential to improve the health sectors competitiveness and productivity.	• Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Productivity Commission(2017) • National Commission of Audit – Towards Responsible Government (2013)

Establishment (or expansion) of Health Care Homes (or similar) model of care.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015)
Adopt patient centred models of care. Australian governments should re-configure the health care system around the principles of patient-centred care within a set timeframe.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015)
Renewed focus on multidisciplinary care in designing and delivering health services.	• Medicare Benefits Schedule (MBS) Review (2015-ongoing) • Healthier Future for All Australians, National Health and Hospital Reform Commission (2009)
Improved integration and continuity between health and aged care services.	• Healthier Future for All Australians, National Health and Hospital Reform Commission (2009)
Healthcare Quality and Safety	
Discontinue funding of MBS items that are shown to not meet safety and quality standards.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Medicare Benefits Schedule (MBS) Review (2015-ongoing) • Efficiency in Health, Productivity Commission (2015) • National Commission of Audit – Towards Responsible Government (2013)
Promptly disseminate best practice guidelines and 'do-not-do' lists to health professionals as they are updated in line with international evidence and standards.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Efficiency in Health, Productivity Commission (2015)

Remove PHI coverage for a range of natural therapies that lack evidence and do not align with best practice quality care.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Private Health Ministerial Advisory Committee (PHMAC) recommendations (2017)
Establishnew performance reporting requirements for health service providers.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015)
Publish more information on the performance of individual healthcare providers.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Efficiency in Health, Productivity Commission (2015)
The Enablers: Health Workforce; Information and Research; Medical Products and Technologies	
Invest in eHealth to improve system performance.	• Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Productivity Commission(2017) • Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Building a 21st Century Primary Health Care System, Department of Health and Ageing (2010) • Healthier Future for All Australians, National Health and Hospital Reform Commission (2009) • Australia: The Healthiest Country By 2020, National Preventative Health Taskforce (2009)
Changes to workforce scope of practice to improve flexibility in the provision of care.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Efficiency in Health, Productivity Commission (2015) • Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015) • National Commission of Audit – Towards Responsible Government (2013) • Building a 21st Century Primary Health Care System, Department of Health and Ageing (2010)

Improve access and the use of patient information and data to achieve better coordination of care.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Efficiency in Health, Productivity Commission (2015) • Building a 21st Century Primary Health Care System, Department of Health and Ageing (2010) • Healthier Future for All Australians, National Health and Hospital Reform Commission (2009) • Australia: The Healthiest Country By 2020, National Preventative Health Taskforce (2009)
Improve information transparency to ensure consumersare making informed decisionsregarding their healthcare.	• Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Productivity Commission(2017) • Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Efficiency in Health, Productivity Commission (2015) • Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015)
Need for improved evaluation and innovative research within Australia's health system.	• Shifting the Dial: 5 year Productivity Review, Productivity Commission (2017) • Efficiency in Health, Productivity Commission (2015) • Better Outcomes for People with Chronic and Complex Conditions, Primary Health Care Advisory Group (PHCAG) (2015) • Building a 21st Century Primary Health Care System, Department of Health and Ageing (2010) • Healthier Future for All Australians, National Health and Hospital Reform Commission (2009) • Australia: The Healthiest Country By 2020, National Preventative Health Taskforce (2009)

Appendix 4: Case study in reform

Case study 1: Health care financing – public hospitals

In 2009, the National Health and Hospital Reform Commission (NHHRC) recommended significant system stewardship changes to create one health system and to significantly realign roles and responsibilities relating to funding and operation of health services. Briefly, the proposal was for the Commonwealth to fund 100% of the efficient cost of services – in combination with the recommended full funding responsibilities of the Australian Government for primary health care and aged care, these changes would mean the Australian Government would have close to total responsibility for government funding of all public health care services across the care continuum – both within and outside hospitals. The progress of public hospital funding is considered below.

Year	Platform or review	Development
July, 2009	Council of Australian Governments (COAG)	The ideals of one health system – and the progressive takeover of funding responsibilities for public hospitals – was endorsed when COAG agreed to the 'Health Australia Accord'.
March, 2010	A National Health and Hospitals Network for Australia's Future – Department of Health and Department of Prime Minister and Cabinet response to NHHRC	Prime Minister Rudd proposed the Commonwealth become the 'majority funder' of public hospitals, and provide: 60% of the 'efficient' cost of service provision directly to hospitals; 60% payment for teaching, research and capital; and, 100% of 'efficient' payment for State-run primary care. The Commonwealth would also set performance standards, and hospitals would be governed by local 'Hospital Networks'. This would leave the states responsible for 40% throughput payment to hospitals and 40% teaching, research and planning, and any cost 'over-runs'. The following agencies were proposed: • Independent Hospital Pricing Authority (IHPA) to set efficient prices • Australian Commission on Safety and Quality in Health Care to set and monitor quality • National Performance Authority to set and report on performance The PM also proposed the Commonwealth withholding one-third of state GST receipts to fund 'hospital takeover'. Victoria, Western Australia and New South Wales were firmly opposed.

April, 2010	COAG	The National Health and Hospital Network agreement proposed was formally proposed but the States remain opposed to changes in GST receipts. The Commonwealth offered Victoria an additional $800 million for hospital beds agreed to meet the cost increases from growth in population and demand, with an additional A$16 billion guaranteed for hospitals through to 2019 [even if that exceeded actual increases]. This would mean the Commonwealth had no role in negotiating which services – and how many – are delivered at each public hospital; the agreement explicitly excluded any federal role in shaping service contracts between states and local hospital networks. The agreement was not signed.
August, 2011	National Health Reform Agreement	The National Health Reform Agreement (NHRA) was agreed by all states, territories and the Commonwealth in August 2011. The important components include: • The Commonwealth would share the costs of growth, paying for 45% of new costs in the period July 1st 2014 to June 30th 2017 and 50% of new costs thereafter, which included a 'betterment' factor of around 2% per annum recognizing that hospital admissions grow faster than the population. • The relevant costs would be based on a 'national efficient price' (NEF) determined by the (IHPA) • Significant funding to address long waiting time for elective procedures and other system reforms through a hospital funding pool of $16.4 billion The NHRA embodied a Commonwealth/States partnership to improve health outcomes and ensure the sustainability of the health system. The States were confirmed as systems managers for public hospital services.
May 2014	Federal Budget, 2014-15	Following recommendations from the NCOA, the NHRA would last until 2017 and then be reversed to CPI plus population growth – there would no longer be a betterment factor. That is, Activity Based Funding (a methodology based on the level of hospital activity and the complexity of cases (case-mix) using the NEP to calculate these costs) would be abolished from 2017 onwards. This new arrangement saved the Commonwealth $1 billion annually, but left the States with three broad options: find alternative revenue, find efficiencies, or allow hospital services to deteriorate.

April, 2016	COAG	The Heads of Agreement for public hospital funding from 1 July 2017 to 30 June 2020 reaffirmed universal health care for all Australians is a shared CW/State priority. The agreement returned Commonwealth funding to 45% for three years; with an additional $2.9 billion in funding for public hospital services and growth in Commonwealth funding capped at 6.5% annually. The Agreement also included commitment from States and Territories to improve the quality of care in hospitals; reduce the number of avoidable admissions by improving coordinated care for people with complex and chronic disease; refine hospital pricing mechanisms; and, reducing the number of avoidable hospital admissions.
May, 2016	Federal Budget, 2016-17	As agreed by the Commonwealth at COAG, The Budget provided up to $2.9 billion over three years in additional hospital funding to the states and territories commencing in 2017-18. Commonwealth funding to public hospitals will be $17.9 billion in 2016-17, and $21.2 billion by 2019-2020. This agreement effectively reversed the 2014-15 budget cuts but leaves a longer-term public hospital funding agreement to commence from 1 July 2020 to be agreed by COAG before September 2018.