

16 December 2009

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

Business
Council of
Australia



Dear Minister Roxon

HEALTH REFORM AND THE NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION (NHHRC) FINAL REPORT

Thank you for attending the recent Healthy Australia Task Force meeting and for the open discussion of health reform directions. As promised, I am now pleased to provide on behalf of the Business Council of Australia (BCA) and its Healthy Australia Task Force an overview of our recommendations. I also provide further detail on the proposed market regulatory body discussed at the meeting.

We confine our comments to what we see as the missing economic, strategic and system management elements of the NHHRC's final report. In this we take an economic reform and productivity improvement lens to the debate, since we believe that health has been the missing area of microeconomic reform to date despite having major implications for Australia's overall productivity. Equal attention must be paid to improving the economic performance of the health sector/market as to the clinical and care issues so well identified by the Commission.

We all agree on the challenges facing us: the sustainability of our healthcare system as demand and expectations increase and health workforce numbers lag need; its slowness to re-configure services to meet a changed pattern of disease and treatment; persistent quality problems and inequitable health outcomes. Because service provision is both public and private, we view these as key market failures as well as social failings. The significance of their impact on Australia's economic prosperity through reduced productivity, workforce participation and additional healthcare costs are such that, urgent government action is required.

That action needs to be both *systemic and systematic*, with the aim being to *increase the value for patients* and the health dollar. This requires a reform process that is bigger than the Commonwealth/State divide, important though this is. If the objective is to make the health sector a patient-centric system, the fundamental dynamic of a producer/provider-led sector must be transformed in the same way as in many other Australian sectors in the past two decades. This includes, but is not limited to, considerable strengthening of consumer information and protection mechanisms. This does not mean that we equate consumption in this sector with the consumption of other goods and services, but rather reflects our belief that the introduction of

similar forces and consumer protection mechanisms that have driven greater responsiveness and consumer benefit in other sectors can also be used to help effect the patient-centricity desired for the health sector. This would be appropriate in light of the increasing expectations of them for both health self-management and financial contribution to healthcare that current policy thinking favours.

Re-configuration of services

Our starting point is the need for a *comprehensive national health strategy* that seeks to match projected needs with services. Without this the market signals about future demands for capital, skills and technology are unclear to all potential decision-makers and investors, from current health sector providers to treasuries, from school students deciding on careers to citizens deciding on lifestyles.

We suggested that a way of developing such a strategy within the current morass of blurred accountabilities and the unhelpful politicisation of health, was to establish an *independent planning commission* which could be responsible for identifying needs and the required services to meet these, including continuously updating these to best practice research, articulating this vision and being accountable for the performance of the system.

While greater focus on prevention may reduce demand for healthcare services, we accept the current expert projections that demand will continue to rise faster than supply or the capacity to pay. This shortfall is exacerbated by the configuration of services being less than optimal and resources not as efficiently directed as they could be. Therefore to meet the shortfall and to speed the reconfiguration of services, we need greater incentives to innovation, investment in new service inputs and efficiency. This implies stronger market shaping interventions and/or greater direct government provision are needed. We would suggest the former, in view of the preponderance of private practitioners, the scarcity of public sector investment funding and the greater propensity for innovative solutions to emerge from a diverse market.

Such market shaping mechanisms can include new service specifications and open purchasing arrangements. For this reason, we have recommended the *separation of purchasing from public provision*. In other sectors in Australia and health sectors internationally this has encouraged price competition, service differentiation and, more importantly, innovation.

Stronger price signals to consumers and practitioners alike can also act to shape service demand and supply. Those signals can range from greater incentives to citizens to stay healthy and employers to provide healthy workplaces, to providers to provide different services that reflect the new desired patterns of care. These will be reflected in *revised fee schedules, tax concessions and other incentive payment schemes*.

Financial and clinical sustainability

The current system provides few price signals that might reduce preventable demand or encourage efficiency. As many have noted, the current fee schedules generally reward providers for health cure, rather than health maintenance, and incentives from government to citizens do not include preventative health expenditures, either through the tax or health systems.

To encourage efficiency of providers, we have supported the introduction of *activity-based payments* nationally as a means of setting efficiency benchmarks. However

we understand that in calculating these, government needs to recognise not only best efficient practice, but also any factors that legitimately affect delivery costs. We are also keen to ensure that in the calculation of these costs, the current procedural or episodic focus is not perpetuated unnecessarily and associated costs of clinical teaching and research are not ignored.

We also believe that *urgently addressing the causes of medical errors*, both within hospital and in community settings, is fundamental to both instilling a greater quality culture while at the same time reducing unnecessary costs to the system, individuals and the economy more broadly. Assuming the assessments of the level and costs associated with serious and adverse events are correct, their elimination, or near elimination, would lead to significant savings. In no other sector would this rate of death or injury be tolerated. In no other sector would the implicit error rate and waste be tolerated. The application of root cause analyses and lean manufacturing techniques used to address these problems in other sectors have already been applied successfully within certain health settings internationally but here they need greater incentives and regulatory support.

We have also observed directly and seen the many comments on the dearth of useful data and information in the health system. Not only is there insufficient data available to hold providers and governments accountable, there is inadequate data upon which to develop the strategy identified above, to calculate the payments just described or to prompt the continual performance improvement characteristic of other sectors. Moreover, the information and data that is collected is inconsistent, error prone and stored in ways that its potential value cannot be captured. As a knowledge-intensive sector, it is remarkable that e-health has not been adopted as a major source of improved productivity. Our understanding of the cause of this market failure has led us to recommend the *urgent investment by governments in a national e-health infrastructure and the connection of major public institutions into that infrastructure*. The capacity to meet the projected demand for healthcare in the light of constrained workforce and public funding, demands that all avenues to support greater productivity are pursued. E-health initially might only streamline and improve the accuracy of data and reduce the duplication currently implicit in the system, but even these benefits will reduce costs and transaction costs for both funders and patients. Over the medium to longer-term we would expect that the additional connectivity will engender different and more productive ways of working, as they have in all other sectors.

Although we believe that additional signals to providers on efficient and effective practice are needed, we also strongly believe they need to be accompanied by significantly stronger *information on costs/prices, options and outcomes to patients and their advisors*. Not only do 'consumers' have access to less relevant information to guide their decisions in healthcare than in almost all other sectors of economic activity, Australian health consumers have less available than their overseas counterparts. We recognise that there will always be an asymmetry in information between health professionals and patients, but there can be little excuse for a similar dearth for their advisors or in instances where government increasingly expects patients to contribute more (directly or indirectly) for their care or to take more responsibility for their own health management. In other sectors where information has been increased for consumers, greater responsiveness by providers has developed. We would expect this to occur in health as well, particularly as the education levels of the population increase.

Persistent quality issues

As noted above, the quality and patient safety issues recorded first in 1995 are still persisting in the absence of systemic and compulsory action to protect patients. Even more remarkable is that, while noting the equivalence of a jumbo crashing every week, the NHHRC's proposed actions are to take many more years to take effect. This delay in addressing urgent issues of life and death was not countenanced in the aviation or other consumer sectors and it should not be tolerated in this sector. Moreover, the lack of transparency of the risk for potential patients is unconscionable and clearly at odds with statements about redesigning the system to be patient-centric. To address this market failure we have recommended that information on outcomes be part of a set made available for patients immediately. Further that *an independent market regulatory body* be established to collect and publish such data by institution and practitioner and that this system be linked to ongoing accreditation of both, as part of a *strengthened quality assurance* framework. There is more on this subject in the attachment.

Distribution of outcomes

Clearly, the inequity of health outcomes belies the claims of a universal healthcare system. These inequities reinforce and help entrench the cycle of social disadvantage, making it difficult for those affected to participate fully, economically or socially. While recognising that breaking the cycle requires a multi-faceted and whole-of-government response, such inequities in the health sector can again be seen as a market failure. The highly correlated inequitable access to services can be addressed through either direct provision, or access to provision, or through *greater incentives* to encourage private provision.

In conclusion, the healthcare system needs to be treated as a system, both from the patients' perspective and from a management perspective. If the current health reform package is not treated as an economic issue as well as a clinical issue, then not only will opportunities be lost to achieve productivity improvements within the sector and more broadly, but also the sustainability of the clinical reforms is in doubt. Australia is well served by its mix of public and private sector provision and the failures we have observed largely flow from out-dated regulatory structures and schedules. As governments consider how these can be changed to achieve the healthcare system we need for the 21st century, it would be useful to use an economic lens to shine light on how the health market performance might be improved. In saying this, however, we understand clearly that local governance and clinical input through the Colleges is a critical part of the implementation process. The objective should be improving the value for patients.

Yours sincerely



Katie Lahey

cc The Hon Wayne Swan, Treasurer
Nigel Rae, Department of the Treasury
Peter Robinson, Department of the Treasury

Attachment: A National Supervisory Commission for Health***Addressing governance of the health sector to improve its responsiveness to patients, productivity, effectiveness and quality.******Preamble***

The current configuration of the health sector is materially shaped by its acute care history on many dimensions including: the clinical specialties and their interaction, capital allocation to facilities, workforce employment patterns, clinical training, and training of allied health workers. This configuration interacts with the multiple layers of government funding and management and comprehends also substantial private sector operations.

To support systemic and systematic reform that re-orientes the sector to the patient and promotes quality, together with both process and technical improvement, new governance structures must be implemented, both at the system level and at the local level.

In a separate paper, the BCA has outlined the functions of a national planning commission and proposed governance arrangements for public providers. In this paper we elaborate the functions of a supervisory body that would provide assurance to both patients and commissioning authorities that the providers operating in the sector are appropriately qualified to provide the services, have the appropriate facilities and operating procedures to support them, are financially stable and deliver the outcomes sought.

Such assurance would be provided through the setting of national standards, a licensing system, processes for investigating breaches of operational standards and publication of information. Such processes would be closely aligned to the accreditation of those practising in the sector, both at appointment and on an ongoing basis.

Citizens are increasingly being expected to take more responsibility for their own health and to pay greater contributions towards their healthcare. This implies greater involvement in decision-making about their lifestyles and choices of health interventions. But patient choice (either directly or under advice from a clinical advisor) can only be exercised when there is full and reliable information about the nature, timeliness, effectiveness and costs of treatment options, the services available and the relative merits of alternative providers.

Currently access to such information is limited. Provision of such information is the equivalent of market information provided in many other sectors of the economy, either by government or through independent bodies under regulation – from the financial services sector, to utilities, education and general consumer activity. Health is one of the few sectors in which full disclosure of cost, patient responsibilities and outcomes is not consistently available. It is also one of the few sectors in which public disclosure around errors occasioning death and injury is not readily available. A critical function of this body, therefore, will be the provision of reliable and accessible information to enable informed patient choice.

Objective

The Commission would be a single independent, national body with a system wide remit, making use of regulatory and prudential oversight tools (transparency, accountability, adherence to standards) to build confidence in the integrity of Australia's health system and influence how healthcare is delivered through both the public and private sectors.

Its objectives would be to:

- maintain, facilitate and improve the performance of the health system and its providers
- promote confident and informed participation by consumers and providers in their health care
- establish and enforce standards and practices designed to ensure that, under all reasonable circumstances, healthcare is delivered by healthcare providers within a stable, efficient and competitive system that seeks to ensure that patients and the public interest are protected
- promote best practice in quality, safety and operational effectiveness

Functions

As an independent authority, the National Supervisory Commission for Health would regulate the operations of the sector, including public and private sector providers. Its key functions would include:

- developing and implementing governance standards
- gathering data, conducting analyses and reporting on the sector's effectiveness
- identifying and publishing key metrics, including where relevant, performance ratings
- making findings and supervising remediation plans regarding non-compliance with quality and governance standards
- conducting reviews into the effectiveness of sector activities and publishing reports, at both its own initiation and on request from government or the health planning authority
- licensing and/or accrediting sector participants

Powers

The powers of the Commission would include:

- the power to require data and information from providers offering services to the public

- the power to publish annual reports on the performance of providers as a basis of informing consumers, advisors and funders of their performance and ongoing viability
- the power to investigate complaints and potential breaches of accreditation standards
- the power to license providers and to remove licences to operate where public safety and/or governance and/financial viability is in jeopardy

Replacing

The Commission would incorporate relevant existing bodies, such as the Australian Commission on Safety and Quality in Health Care and the Australian Institute of Health and Welfare and in these cases connect, extend and strengthen the work of these bodies by including them within the suitably empowered Supervisory Commission.

It would work with accreditation and professional bodies to ensure that practitioner accreditation (new and ongoing) met evolving professional standards and would use those accreditations to license practitioners to operate and receive public funding.

It would work with the appropriate bodies (or replace them) to ensure that accreditation processes were in place for institutional providers (eg public and private hospitals) to assure the public and funding bodies of their ongoing performance, governance and financial viability.

Explanation

In conception the Commission would draw on the experience of local, more narrowly focused institutions and also on relevant international bodies such as the UK Safety and Quality Commission. In large measure, however, its regulatory role and stance would also be informed by the successful models of regulation in the Australian financial services sector, particularly the risk management and standards based operations of the Australian Prudential Regulatory Authority (APRA). Its role would therefore favour a flexible principles-based approach focused on outcomes, rather than a detailed rules-based approach.