



Australian Government

***A NATIONAL HEALTH AND
HOSPITALS NETWORK:
FURTHER INVESTMENTS
IN AUSTRALIA'S HEALTH***



A National Health and Hospitals Network: Further Investments in Australia's Health

ISBN: 978-1-74241-196-5

Online ISBN: 978-1-74241-197-2

Publications Number: P3-6523

Copyright Statements:

Paper-based publications

© Commonwealth of Australia 2010

This work is copyright. Apart from any use as permitted under the *Copyright Act 1968*, no part may be reproduced by any process without prior written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Attorney-General's Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at <http://www.ag.gov.au/cca>

Internet sites

© Commonwealth of Australia 2010

This work is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use or use within your organisation. Apart from any use as permitted under the *Copyright Act 1968*, all other rights are reserved. Requests and inquiries concerning reproduction and rights should be addressed to Commonwealth Copyright Administration, Attorney-General's Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at <http://www.ag.gov.au/cca>



Australian Government

***A NATIONAL HEALTH AND
HOSPITALS NETWORK:
FURTHER INVESTMENTS
IN AUSTRALIA'S HEALTH***



TABLE OF CONTENTS

Overview	1
Chapter 1: Hospitals	23
Chapter 2: GP and primary health care	36
Chapter 3: Workforce	51
Chapter 4: Aged care	63
Chapter 5: Building the National Health and Hospitals Network	82
Appendix A	94

FOREWORD

A National Health and Hospitals Network: Further Investments in Australia's Health

Stage two of the Government's National Health Reform Plan

Over the past two years the Australian Government has taken on the enormous challenge of reforming our health and hospitals system to meet the needs of patients today and the growing demand for health services in the future.

In 2008, we made record investments in the health and hospitals system and commissioned the most comprehensive assessment of our health and hospitals system in more than two decades through the National Health and Hospitals Reform Commission.

In 2009, we took the Commission's recommendations to more than one hundred health forums around the nation, hearing from the patients, clinicians and health experts at the heart of our health system.

Last month, we announced the most far-reaching structural reforms to the health system since the introduction of Medicare, with the establishment of a single National Health and Hospitals Network that is nationally funded and locally run.

In announcing these structural reforms to put Australia's health care system on a sustainable funding basis, we also indicated our intention to implement major improvements in the frontline delivery of health care to Australians.

This document outlines the next stage of our health reforms, to deliver substantial improvements in the quality and availability of health care for Australians.

For the first time, Australians will have a guarantee that they won't have to wait too long for elective surgery.

For the first time, a four hour National Access Target will be established for hospital emergency departments.

For the first time, the Government will pay for better health outcomes rather than just one-off visits to doctors and specialists – through our plan for personalised care for patients with one of Australia's most common chronic diseases, diabetes.

For the first time, the Government will assume full responsibility for aged care in Australia, allowing us to deliver immediate improvements to help older Australians and their families better navigate the aged care system.

The Government will deliver record investments in training more doctors and allied health workers – so that in the future, patients can get better access to health services when they need them.

The structural reforms already announced by the Government give us confidence that our increased investments in our National Health and Hospitals Network will deliver real improvements to patient care.

Health reform is ultimately about one thing – better health and hospitals for all Australians. This second stage of the Australian Government’s National Health Reform Plan will help achieve our goal for all Australians to enjoy access to high quality, better coordinated and sustainable health care in the decades ahead.



The Hon. Kevin Rudd MP
Prime Minister



The Hon. Wayne Swan MP
Treasurer



The Hon. Nicola Roxon MP
Minister for Health and Ageing

April 2010

OVERVIEW

1. *Investing in the National Health and Hospitals Network*

Earlier this year, the Government announced the establishment of a National Health and Hospitals Network – the most significant reforms to Australia’s health and hospital system since the introduction of Medicare, and one of the biggest reforms to the federation in its history. The National Health and Hospitals Network will drive major improvements in service delivery and better health outcomes for patients. It will equip the health and hospital system to serve Australians well into the future, and repair the finances of the Australian federal system.

The Government is now outlining major additional investments in the National Health and Hospitals Network to deliver better health and better hospitals for all Australians. From July 2010, the Government will invest \$3.0 billion across:

- › **Hospitals** – to reduce waiting times for emergency departments and elective surgery.
- › **General practice (GP) and primary health care** – to improve access to GP services, tackle chronic disease and keep Australians healthy and out of hospital.
- › **Workforce** – to ensure there are more health professionals to meet the growing need for health and hospital services across the country.
- › **Aged care** – to improve access to high quality aged care and health services for older Australians.

These investments focus on the health services that Australians rely on most to keep them healthy, and to help them get better if they happen to fall ill. They will improve patients’ experience of the health and hospital system wherever they live.

For the first time, Australians will have a guarantee that they won’t have to wait too long for elective surgery.

For the first time, a National Four Hour Target will be established for hospital emergency departments.

For the first time, the Government will pay for better health outcomes rather than just one-off visits to doctors and specialists – through our plan for personalised care for patients with one of Australia’s most common chronic diseases, diabetes.

For the first time, the Government will assume full responsibility for aged care in Australia, delivering immediate improvements to help older Australians and their families better navigate the aged care system.

The Government will also deliver record investments in training more doctors so that in the future, patients can get better access to health services when they need them.

The Government is confident that these reforms will deliver significant improvements in services for patients, building on the major reforms to the structure of the health and hospital system that the Government has already outlined. Under the National Health and Hospitals Network:

- › The Commonwealth Government will become the majority funder of Australian public hospitals, by funding 60 per cent of the efficient price for all public hospital services that Local Hospital Networks have agreed to provide, as well as 60 per cent of capital, research and training in our public hospitals.
- › The Commonwealth Government will take full funding and policy responsibility for GP and primary health care services in Australia.
- › Under these new funding arrangements, the Commonwealth Government will pay for the majority of growth in public hospital costs over time, including growth over and above the share of Goods and Services Tax (GST) the Commonwealth is allocating to a National Health and Hospitals Network Fund.
- › The Commonwealth Government will require new, higher national standards and transparent reporting that will provide Australians with more information than ever before about national, state and local performance of the health system.
- › Responsibility for hospital management will be devolved to Local Hospital Networks. This will increase local autonomy and flexibility so that services are more responsive to local needs.
- › The Commonwealth Government will pay Local Hospital Networks directly on the basis of an efficient price per public hospital service they provide to public patients under service agreements between each Local Hospital Network and states. While paying Local Hospital Networks is integral to the National Health and Hospitals Network, some payments are still best made at the state level to allow for system-wide resource allocation. This is particularly true for research, training and block grants for small rural and regional hospitals to recognise Community Service Obligations.

The establishment of the National Health and Hospitals Network will reduce cost shifting and blame shifting. It will ensure that for the first time, the Commonwealth Government pays a fixed majority share of public hospital funding, as opposed to the current situation in which the Commonwealth's hospital funding share has been declining year after year. Having one level of Government responsible for both the majority of hospital costs and all of GP and primary care services will clear up the perverse incentives that exist in the current system. For the first time, the Commonwealth will have a major financial incentive to provide better services outside of hospitals and drive improved efficiency and standards in hospitals.

It will also underpin the financial sustainability of the our health and hospital system, by ensuring that state and territory government budgets are not consumed by rising health costs. The Commonwealth Treasury forecasts this to occur by 2045–46, and earlier in some states and territories (referred to throughout this document as 'states'). Under the National Health and Hospitals Network, states will be relieved of a growing fiscal pressure, beginning with a projected \$15.6 billion between 2014–15 and 2019–20.

The National Health and Hospitals Network builds on the major investments and existing reforms that the Government has already made in Australia's health and hospitals system. These include:

- › record investments in public hospitals;
- › training a record number of doctors, nurses and allied health professionals;
- › making smarter use of our workforce;
- › reforming incentives for doctors to go to rural areas;
- › building GP Super Clinics across the country; and
- › making record investments in prevention.

2. *Areas requiring additional investment*

The work of the National Health and Hospitals Reform Commission (NHHRC) and the 103 consultations conducted by the Government around the country identified a number of critical pressure points in the system requiring additional investment.

2.1 *Waiting times in public hospitals*

Our public hospital system is struggling to cope with growing patient demand and stretched budgets. For more than half a decade, almost one in six people seeking elective surgery operations and one in three people attending emergency departments have been waiting longer than the recommended time for treatment:

- › Since 2001–02, at least 31 per cent of people attending emergency departments have waited longer than the recommended time for treatment.
- › Since 2002–03, around 16 per cent of elective surgery patients also waited longer than the recommended time for treatment.

In addition, nearly a third of patients admitted to a bed from an emergency department wait more than eight hours between the time they arrive and when they are finally transferred to a bed in a ward.

Changes are needed to create additional capacity in the system to meet growing demand and better meet community expectations.

Australia's rates of hospital admission are above the OECD average and significantly higher than comparable countries such as the United States, New Zealand, and Canada. This pressure and constant strain on resources is also felt in the everyday working lives of health professionals.

For this reason, changes are also needed to reduce the pressure on our hospitals by keeping people healthy and providing care in the community.

2.2 *Safety, quality and clinical performance*

The National Health and Hospitals Reform Commission indicated that adverse events result in approximately 4,550 unnecessary deaths a year and add a cost of around \$2 billion annually to the health budget.

The Australian Commission on Safety and Quality in Health Care was established by governments to lead and coordinate the safety and quality agenda in Australia's health system, but clinical engagement is also fundamental to maintaining and improving clinical performance. In the Government's consultations on health reform, many clinicians made it clear they do not feel they have the opportunity to be involved in decisions about the delivery of health services in their community. The devolution of responsibility for hospital management to Local Hospital Networks provides a critical basis for improved clinical performance, but more will need to be done.

2.3 Barriers to access to GP and primary health care services

Many patients are unable to access the GP and primary health care services they need because there are not enough GPs and other health professionals located nearby. For example, Australians in areas with high levels of access to health services have 46 per cent more spent on them through Medicare than Australians living in remote areas, and 160 per cent more spent on them than Australians in very remote areas.

Limited planning for GP and primary health care services – including poor identification of and response to gaps in services – contributes to this. The Medicare Benefits Schedule (MBS), which is the principal means by which GP and primary health care is funded in Australia, provides limited support for GPs and primary health care professionals to work together – and with other health providers such as hospitals and aged care providers – to improve patient care.

Divisions of General Practice play some role in filling access gaps and better coordinating care, but lack the resources or the breadth of scope to be able to drive the major change needed.

Access gaps and poor coordination between services contribute to high rates of hospitalisation in Australia, a proportion of which could be avoided. The Australian Institute of Health and Welfare has estimated that potentially preventable hospitalisations represented 9.3 per cent of all hospitalisations in 2007–08. This equates to about 441,000 hospitalisations in public hospitals, with an average cost of \$4,230 per episode of care.

2.4 The large and increasing burden of chronic disease

Chronic diseases already represents a major challenge for Australia's health and hospital system, and are estimated to be responsible for more than 80 per cent of the burden of disease and injury in Australia. More than 50 per cent of GP consultations are for people with a chronic condition.

The burden of chronic disease is projected to dramatically increase into the future. By 2032–33 combined spending on cardiovascular and respiratory diseases is projected to be around \$40 billion annually, while spending on type 2 diabetes is projected to increase by 520 per cent between 2002–03 and 2032–33 (resulting from factors such as ageing, increase in obesity and improvements in treatment and services).

Current funding arrangements can support a focus on helping Australians when they are ill, rather than keeping them well. This does not serve the interests of Australians suffering from chronic diseases, who need more integrated GP and primary health care.

For instance, patients with diabetes often need care from multiple health professionals, including GPs, specialists (such as endocrinologists) and dietitians. Yet many patients with type 2 diabetes experience poorly coordinated care. This contributes to avoidable hospital admissions, poorer health and a reduced quality of life. In 2007–08, over half of the 441,000 potentially preventable hospital admissions to public hospitals were related to diabetes alone.

2.5 Shortages of doctors and other health workers, particularly in rural and remote Australia

Large parts of Australia are experiencing health workforce shortages. Many of the problems with our health system today arise because there are not enough health professionals to meet the demand for services, particularly in rural and regional Australia.

In 2007 it was estimated that 59 per cent of Australians live in an area with a shortage of available doctors. To simply maintain existing levels of GP services Australia will need a further 3,000 GPs over the next decade.

Both the NHHRC and the draft National Primary Health Care Strategy noted overall shortages across a range of the nursing, medical and allied health professions.

Workforce shortages are most acute outside Australia's major cities. The number of GPs per 100,000 head of population varies from under 60 in very remote Australia through to almost 200 GPs per 100,000 people in major cities. The majority of allied health practitioners also work in metropolitan locations. Only 64 allied health workers per 100,000 population work in very remote areas of Australia, compared to 354 per 100,000 in major cities.

2.6 Ensuring our aged care system can meet the needs of growing numbers of older Australians

The aged care system is currently fragmented, with divided responsibilities between the Commonwealth and the states. As the Commonwealth currently provides around 90 per cent of government funding for aged care, duplication and overlap is particularly problematic in community care. Commonwealth-funded packages of community care operate alongside and overlap Home and Community Care (HACC) services, which are jointly funded by the Commonwealth and the states.

Consequences of the split roles and responsibilities between the Commonwealth and the states include:

- › overlap between the services provided by different programs run by different governments, with different cost structures and eligibility requirements;
- › care being too closely tied to program and funding criteria and not responsive enough to people's changing needs; and
- › different quality assurance and complaint systems applying to services funded by the different levels of government.

Older Australians, their families and carers find it hard to access the services they need and often do not know what services are available. This is because different levels of government and different programs tend to offer information on their own services rather than on the aged care system as a whole.

In addition, too many older Australians are unnecessarily admitted to hospital when better care in the community would have kept them healthy and out of hospital. A recent study estimated that 31 per cent of transfers from aged care homes to hospitals (about 27,000 admissions each year) were potentially avoidable.

The supply of high level residential care is not keeping up with increased demand from population ageing. This has been accompanied by falls in recent years in the numbers of registered and enrolled nurses working in residential aged care.

A consequence of this is that too many older Australians spend longer than they need to in acute hospital beds due to a lack of services available in the community. In 2006, about 2,400 patients eligible for aged care were waiting in hospital for an aged care place to become available, with 63 per cent waiting in hospital for more than 35 days. Without action, frail older people will face increasing difficulty in accessing residential aged care services, which will place increasing strain on our hospitals.

A further challenge is that complaints about service provision in aged care continue to increase. For example, there were 6,818 contacts with the complaints system in 2006–07, compared to 12,573 contacts in 2008–09.

3. Reforms to build on the National Health and Hospitals Network

The Government is making additional investments to respond to the challenges outlined above, and build on the package of structural reforms announced last month to establish the National Health and Hospitals Network.

3.1 Taking the pressure off public hospitals

From 1 July 2010, the Government will invest \$1.2 billion to address key pressure points in the public hospital system. This includes:

- › **\$500 million over four years to reduce emergency department waiting times to a maximum of four hours.**
- › **\$650 million over four years to reach a target of 95 per cent of elective surgeries within clinically recommended times, together with a guarantee of free rapid treatment in a public or private hospital if patients wait longer than is recommended.**

These investments will deliver immediate improvements and help lift public hospitals to the new, higher national standards that will be a permanent feature of the National Health and Hospitals Network:

- › **They will result in the equivalent of providing recurrent funding for around 90,000 additional elective surgeries and around 1.2 million additional emergency department services.**

The Government will introduce an annual Hospital Performance Report, rating every Local Hospital Network and every private hospital against new national standards and other performance indicators. This will give Australians more information than ever on the performance of their local hospitals.

The Government will also give clinicians more of a voice in planning and service provision, and drive improvements in quality and safety, building on the improved clinician engagement that the Government's introduction of Local Hospital Networks will deliver.

Notwithstanding the Government's significant investments since 2008, emergency departments and access to elective surgery require further investment and reform. Growing demand means these two critical areas of public hospital service delivery remain under pressure.

This investment will help lift public hospital standards to the new, higher national standards that will be a permanent feature of the National Health and Hospitals Network.

3.1.1 Reducing waiting times in emergency departments

To improve timely treatment in emergency departments, for the first time the Government will introduce a four hour National Access Target. Anyone presenting to a public hospital emergency department anywhere in the country will be admitted to hospital, referred for treatment, or discharged within four hours, where it is clinically appropriate to do so.

To help public hospitals meet these targets, the Government will provide states with \$500 million as facilitation and reward funding. This includes:

- › \$150 million in upfront payments to states starting on 1 July 2010 to deliver immediate improvements. This investment will help provide the capital equipment, system planning and additional capacity elsewhere in hospitals that will be required to lift hospitals to new, high national standards.
- › \$350 million in financial rewards for states that meet or beat their targets.

This funding is sufficient to support around 1.2 million additional emergency department services. Some states, such as Western Australia and South Australia, are already moving more quickly to try to achieve a four hour target on this critical measure of access to public hospital services.

This four hour National Access Target and reward funding will drive improved access to timely and safe emergency department services for patients. Patients and families will have the peace of mind of knowing that when they or a loved one need emergency department care, they will no longer have to spend all night sitting in the waiting room or waiting for a bed. Targets for emergency departments have been shown to be effective in improving waiting times and access to care internationally. The target will be administered consistent with the clinical judgement of doctors.

3.1.2 Improving access to elective surgery

To improve access to elective surgery in public hospitals, the Government will:

- › Introduce a National Access Guarantee for Elective Surgery under which free treatment in public or private hospitals will be rapidly provided if patients wait longer than the clinically recommended time for elective surgery.
- › Introduce a target for elective surgery, so that by 2014, 95 per cent of patients waiting for surgery should be treated within the clinically recommended time, up from the current level of 84 per cent.
- › Invest \$650 million to help hospitals achieve the target and National Access Guarantee. This funding will provide the equivalent of around 90,000 additional elective surgeries across Australia.

A National Access Guarantee for Elective Surgery will give patients practical recourse if they have waited too long for their surgery. Any patient who has waited longer than the clinically recommended time will be fast-tracked for their surgery – including by scheduling their surgery at another hospital (at no cost to the patient) – to ensure that they do not wait significantly longer than the clinically recommended time for elective surgery.

To enforce the National Access Guarantee, states will be required to identify when patients are not being treated on time, and work with patients and Local Hospital Networks to get surgery offered to these patients. This surgery would be provided through other public hospitals in the Local Hospital Network, through another Local Hospital Network, or at a private hospital, with any increase in costs at the state's expense. States' delivery of the guarantee will be monitored by the new independent reporting function and Local Hospital Networks will be required to publicly report on their performance. There will be a single national hotline for people needing the guarantee to be enforced.

In drawing on the resources of both the public and private sectors, the National Access Guarantee will get the best out of the entire hospital system, and recognise the critical role of private hospitals in relation to elective surgery.

Under the target, the Government will aim to increase the proportion of patients treated within the clinically recommended time to 95 per cent.

The Government will support this target and Guarantee through a \$650 million investment, which includes:

- › \$300 million in upfront payments starting from 1 July 2010 to help clear waiting lists. This investment will help lift the hospital system to the new, higher national standards.
- › \$350 million in financial rewards for states that meet or beat their targets. This funding will be on top of the funding the hospitals receive for the procedure.

Appropriate clinical standards will be stringently enforced to ensure guarantees and targets are not met at the expense of quality of care.

3.1.3 *Transparent Hospital Performance Reports*

The Government will introduce clear and transparent reporting on the performance of every Local Hospital Network through annual Hospital Performance Reports. This will show how Local Hospital Networks perform against new national standards and other performance indicators, including on:

- › emergency department waiting times;
- › elective surgery waiting times;
- › adverse events in hospitals;
- › quality of care (for instance through reporting on re-admission rates);
- › patient satisfaction; and
- › financial management.

Hospital Performance Reports will provide Australians with more information than ever before about the performance of their Local Hospital Network, and the hospitals within it, and every private hospital. This information will also help health care providers promote a culture of continuous improvement. These reports will be complemented by equivalent Healthy Communities Reports to provide better information on primary care performance.

3.2 *GP and primary health care*

To deliver better health care in the community and take the pressure off our hospitals, the Government will:

- › **Establish independent primary health care organisations with strong links to local communities and health professionals – to improve access to services and drive integration across GP and primary health care services.**
- › **Transform the way Australians with long term illness are treated with a \$436 million investment in coordinated care for Australians living with diabetes.**
- › **Invest \$339 million to double the number of GP training places (as described in chapter three).**
- › **Deliver better GP and primary health care in aged care (as described in chapter four).**

As the majority funder of the hospital system, and the exclusive funder of GP and primary health care services delivered outside of hospitals, for the first time the Commonwealth Government faces a major financial incentive to improve primary health care services. That is why the Government will support its takeover of full funding and policy responsibility with major investments in GP and primary health care.

These investments will deliver more integrated care for patients with diabetes and improve access to high quality GP and primary health care services. Improving care in the community will help keep patients healthy, taking the pressure off our public hospitals and helping to ensure the financial sustainability of our health and hospital system.

3.2.1 New primary health care organisations

The Government will support the establishment of primary health care organisations across Australia. These organisations will improve the delivery of primary health care services at the local level – for example, through facilitating access to allied health services for patients with chronic conditions. By coordinating these kinds of services, primary health care organisations will ensure local primary care is better integrated and more responsive to the needs and priorities of patients and communities. These organisations will work closely with Local Hospital Networks to identify and address particularly local needs.

Primary health care organisations will be independent legal entities (not government bodies) with strong links to local communities, health professionals and service providers, including GPs, allied health professionals, practices and Aboriginal Medical Services. They are integral to delivering a National Health and Hospitals Network which is nationally funded, but locally run. It is expected that the first primary health care organisations will commence operations by mid 2011 with the rest to be rolled out in mid 2012.

Primary health care organisations will be responsible for a range of functions aimed at making it easier for patients to navigate the local health care system and to provide more integrated care. For example, they will:

- › Facilitate allied health care and other support for people with chronic conditions, as identified in personalised care plans prepared by GPs.
- › Work with local health care professionals to ensure services cooperate and collaborate with each other so that patients can easily and conveniently access the full range of services they need.
- › Identify groups of people missing out on GP and primary health care, or services that a local area needs, and better target services to respond to these gaps.

- › Work with Local Hospital Networks to assist with patients' transition out of hospital, and where relevant into aged care.
- › Deliver health promotion and preventive health programs targeted to risk factors in communities in cooperation with the Australian National Preventive Health Agency, once it is established.

Over time, primary health care organisations will improve the delivery of and access to primary health care services at the local level. This will ensure that there will be fewer gaps in services, particularly for patients with chronic conditions and special needs. Patients will also find it easier to navigate the local health system to find the services they need. There will be smoother transitions between service providers and greater coordination of services.

3.2.2 Coordinated care for patients with diabetes

To respond to the rapidly rising incidence of chronic disease, the government will invest \$436 million to transform the way patients with chronic disease are treated – beginning with the nearly one million patients who suffer from diabetes.

For the first time, patients diagnosed with diabetes will have the option to enrol with a general practice of their choice to receive high quality coordinated care, and access a range of additional services.

Patients will be able to enrol with a GP practice that will:

- › become responsible for managing their care, including by developing a personalised care plan;
- › help organise access to the additional services they need, such as care from a dietitian or podiatrist, as set out in their personalised care plan; and
- › be paid, in part, on the basis of their performance in keeping their patients healthy and out of hospital.

Practices will be able to use Government funding flexibly to deliver and purchase the full range of services that patients need. The Government will work with patient and health consumer representatives and key primary health care groups, including GPs and allied health providers, on detailed implementation arrangements for this policy. This includes the development of a performance framework.

Importantly, patients will continue to be able to see any GP of their choice.

3.2.3 Improving access to GP services in aged care

The Government will invest \$96 million to provide increased financial incentives for GPs to provide services in aged care homes. This is expected to deliver an extra 105,000 services to aged care recipients in the four years to 2013–14. By improving their access to GP services, this measure will help older Australians receive the care they need in their usual place of residence, reducing unnecessary visits to hospital.

The Government will also provide funding for primary health care organisations from 2012–13 to increase access for older Australians to GP and primary health care. This is expected to result in an additional 190,000 primary health care services in the two years to 2013–14 (this is further discussed in chapter four).

3.3 Building Australia's health workforce to deliver better health and better hospitals

The Government has already announced that it will make a \$643 million investment to train more doctors and allied health professionals, and make the most of the skills and dedication of our existing workforce. The Government will deliver:

- › **1,375 more general practitioners (GPs) practising or in training by 2013, and 5,500 new GPs or GPs undergoing training in the next decade (\$339 million);**
- › **975 places each year for junior doctors to experience a career in general practice during their postgraduate training period (\$148 million);**
- › **680 more specialist doctors in the next decade (\$145 million);**
- › **400 more clinical training scholarships over four years for allied health students in rural and regional areas (\$6 million); and**
- › **a rural locum scheme to support 400 allied health professionals, to help them access ongoing education and holiday cover (\$5 million).**

These investments build on the Government's commitment to permanently fund 60 per cent of the costs of training undertaken in public hospitals, which will make the Commonwealth Government the majority funder of training future doctors, nurses and allied health professionals. They also reflect the Government's determination to deliver improved standards of care across the entire National Health and Hospitals Network.

The Government recognises the importance of addressing critical shortages in the nursing workforce and the poor retention rates for nurses who are training and who are already in the workforce. This is particularly important in rural areas as nurses can often be the only health professionals available in small communities in rural and remote Australia.

The Government also recognises the importance of improving retention rates both in the workforce and during study, particularly in rural Australia, through improving clinical training, expanding the opportunities for nurses to improve their skills and provide more flexible working arrangements in rural Australia. The Government will have more to say about this in the near future.

3.3.1 More GPs to improve access to care in the community

The Government will invest \$339 million to increase GP training places to record levels, by raising the number of places available for medical graduates to train to become a GP to 1,200 per year by 2014.

- ▶ This investment will double the annual limit of 600 training places which was in place between 2004 and 2007.
- ▶ By 2013 this will provide 1,375 more GPs in practice or in training, delivering around 5 million extra medical services to the community, when combined with other investments made since 2007.
- ▶ As part of this investment, the Government will double the number of GP training places in rural and remote communities to 600 by the year 2014.

The Government will also invest \$148 million to ensure that more junior doctors can experience a career in general practice before they enter a specialist training program. This investment will expand the successful Prevocational General Practice Placements Program (PGPPP), more than doubling the number of places available from around 400 in 2010 to 975 places each year by 2013–14. This will provide an additional 575 students per year with the opportunity to undertake a 10 to 12 week placement in general practice.

3.3.2 Training record numbers of specialist doctors

From 2011, the Government will provide \$145 million to train more specialist doctors where the community needs them. This investment will more than double the current number of specialist training rotations in the community and private sector from 360 to 900 by 2014, when combined with recent Government investments. It will deliver the equivalent of 680 specialists into the health system by 2020. Priority will be given to providing training places in the communities where Australians need them, such as in rural and regional areas.

3.3.3 Boosting allied health in rural and remote Australia

The Government will build on the steps it has taken to address workforce shortages in rural and regional Australia by:

- › Providing \$6 million for 400 more one year scholarships for allied health clinical placements over the four years to 2013–2014. This will more than double the number currently available each year, and will help students experience clinical practice in regions with a significant workforce shortage.
- › Establishing a new \$5 million rural locum scheme for allied health professionals, to help them take leave or attend training and professional development.

3.3.4 Supporting nurses to stay in the workforce

The Government recognises the importance of addressing critical shortages in the nursing workforce. This is particularly important in rural areas as nurses can often be the only health professionals available in small communities in rural and remote Australia. The Government will have more to say about this in the near future.

3.4 Better supporting older Australians by investing in aged care

The Commonwealth Government will reform the governance of aged care and become the sole funder of a nationally unified aged care system through:

- › **taking full policy and funding responsibility for aged care services, including a transfer to the Commonwealth of current resourcing for aged care services from the current Home and Community Care (HACC) program, to develop and deliver a nationally consistent aged care system; and**
- › **creating a network of one stop shops to be a first and central point of contact for people needing information and access to aged care.**

To improve older Australians' access to appropriate care in the community, and help take the pressure off public hospitals, the Government will make a \$739 million investment in aged care (including directing \$280 million to the states to support older Australians eligible for aged care in public hospitals). In total, this investment will support around 5,000 places or beds and 1,200 packages of care.

The Government will invest more to increase the capacity of the aged care system by:

- › providing more Zero Real Interest Loans to support the development of 2,500 additional aged care places (\$143 million); and
- › providing capital funding for 286 sub-acute beds or bed-equivalents in Multi-Purpose Services (\$120 million).

The Government will invest more to increase the provision of services in aged care through:

- › \$96 million over four years to improve access to GP and primary health care services for people receiving aged care;
- › \$10 million to improve the viability of community care providers;
- › allocating up to 2,000 time-limited flexible aged care places to states and providing an estimated \$280 million in funding for these places for Long Stay Older Patients over the next four years; and
- › 1,200 Consumer Directed Care packages, through which care recipients have a greater say in how services are provided to them.

The Government will also strengthen consumer protections in aged care and toughen prudential requirements to protect residents' savings (\$25 million).

These reforms build on the Government's commitment to take majority funding responsibility for Australia's public hospitals and full funding and policy responsibility for GP and primary health care services delivered outside of hospitals. By improving access and quality of care in the aged care system, these reforms will help take pressure off our hospitals, while ensuring the needs of Australia's growing number of elderly people are met.

3.4.1 Improving the governance of the aged care system

The Commonwealth Government will take full policy and funding responsibility for aged care. The Government will develop and deliver a nationally consistent aged care system that will enable older people to seamlessly move from basic help at home to residential care as their needs change. This will provide a platform for greater integration and innovation.

Current arrangements, with roles and responsibilities for community and residential care split between the Commonwealth and the states, lead to cost and blame shifting.

The Government will move towards establishing arrangements that better integrate aged care with the other parts of the health system and help older Australians find and access the services that suit their needs. As a step towards achieving this outcome, the Commonwealth will invest \$32 million over the next four years so that older Australian and their families can:

- › More easily access information and assessment for aged care services, through establishing one-stop-shops across the country.
- › Be linked to assessment services, including through the Commonwealth purchasing some more complex aged care assessment services directly from aged care assessment teams.
- › Be assisted to access services in the place that best suits them.

The Government will work with aged care providers to ultimately ensure that aged care services are coordinated with Local Hospital Networks and primary care services and they work with one another to provide better integrated and more efficient care.

3.4.2 Increasing the capacity of the aged care system

The Government will increase support for investment in aged care and ensure that rural and remote aged care services receive additional assistance, through investments totalling \$263 million over four years. This investment will:

- › expand the Zero Real Interest Loans program to support the construction of an additional 2,500 aged care places (\$143 million); and
- › provide capital funding for 286 sub-acute beds or their equivalent in rural and remote Multi-Purpose Services (\$120 million). An additional 300 beds will be created as a result of an increase to the number of communities eligible for the program.

To support investment in residential aged care facilities, the Government will invest \$143 million to enable the provision of an additional \$300 million in Zero Real Interest Loans. These will support the construction of an additional 2,500 aged care places, providing care for an estimated 3,600 people per year when fully implemented.

The Government will provide capital funding of \$120 million over the next four years for 286 sub-acute beds or bed-equivalents in Multi-Purpose Services, building on the existing 126 Multi-Purpose Services across Australia. Multi-Purpose Services provide integrated health and aged care services, generally in hospital settings, and are an important option for the delivery of hospital and aged care services in rural and remote areas. This investment will support up to 5,400 people a year when fully implemented. The Government will also alter its current guidelines to expand the number of rural communities eligible for Multi-Purpose Service funding. These changes will result in an additional 300 beds, providing care for 420 people each year.

The Government will also work with states and seek their commitment to release more land for aged care and to accelerate planning approval processes, so that aged care places can become operational more quickly.

3.4.3 Increasing the number of services in aged care

The Government will invest more to increase services in aged care through:

- ▶ \$96 million over four years to improve access to GP and primary health care services for people in residential aged care;
- ▶ allocating up to 2,000 time-limited flexible aged care places to states and providing an estimated \$280 million in funding for these places for Long Stay Older Patients over the next four years; and
- ▶ 1,200 Consumer Directed Care packages, through which care recipients have a greater say in how services are provided to them.

From 1 July 2010, the Government will increase financial incentives for GPs to provide services in aged care homes. This is expected to deliver an extra 105,000 services to aged care recipients in the four years to 2013–14. By improving their access to GP services, this measure will help older Australians stay in their usual place of residence, reducing the need to go to hospital.

The Government will also provide funding for primary health care organisations from 2012–13 to increase access for older Australians to GP and primary health care. This is expected to result in an additional 190,000 primary health care services in the two years to 2013–14.

The Government will also provide assistance to states to meet the cost of Long Stay Older Patients in public hospitals. 'Long Stay Older Patients' are older Australians in public hospitals who have been assessed as needing aged care but who cannot be discharged because they cannot access appropriate aged care services.

The Government will allocate 2,000 time-limited flexible aged care places to states, and provide an estimated \$280 million over four years to states to support Long Stay Older Patients in public hospitals. This will provide immediate financial relief to states for the costs of caring for the estimated 2,400 Long Stay Older Patients currently in public hospitals, while the impact of other measures to reduce the number of these patients works through the system.

3.4.4 Improving consumer focus and protection in aged care

The Government will invest a total of \$25 million to improve the consumer focus of aged care and reduce the complexity of current arrangements.

From 1 July 2010, the Government will increase funding for the Aged Care Complaints Investigation Scheme. The Government will also provide older people and their families access to mediation and conciliation as an additional means of addressing concerns. Funding will be provided for additional staff and improved procedures for managing cases. In addition, the case loads of officers will be reduced to ensure investigations can be handled more quickly and thoroughly.

To better protect aged care residents who have paid accommodation bonds from their life savings, the Government will introduce more stringent rules for how bond money can be invested and improved reporting requirements. Without regulatory change there is a risk that approved providers may use accommodation bonds for other than the intended purposes of infrastructure improvement and debt reduction. The Government will consult with consumers and the industry and will work with relevant bodies to strengthen risk based prudential arrangements, with a view to putting new arrangements in place from 1 July 2011.

In addition to the above reforms, the Government will also provide the Productivity Commission with terms of reference for an inquiry into the aged care system following consultation with the states – to set out a path for reform to ensure that the sector is equipped to deal with future challenges. These will be released at the April COAG meeting.

4. Next steps

The Government's reforms and investments in this document and the structural reforms outlined in *A National Health and Hospitals Network for Australia's Future* focus on the most critical points in our health system. They deliver more investments and better services to patients right now in relation to hospitals, GP and primary health care, and aged care. They make the structural reforms, and the investments in training more doctors and allied health workers, to deliver accessible and high quality health care that is financially sustainable into the future. Figure 1 below demonstrates the substantial level of investment the Government is making in the health system. Further details are also in Appendix A.

Beyond the investments described in this second stage of the National Health Reform Plan, the Government continues to work with states and other stakeholders to identify further high priority opportunities for reform and investment which could be delivered in the future to support the establishment of the National Health and Hospitals Network.

Additional funding directed to the Government's reforms will be provided consistent with the Commonwealth Government's fiscal rules, including holding spending growth to two per cent in real terms.

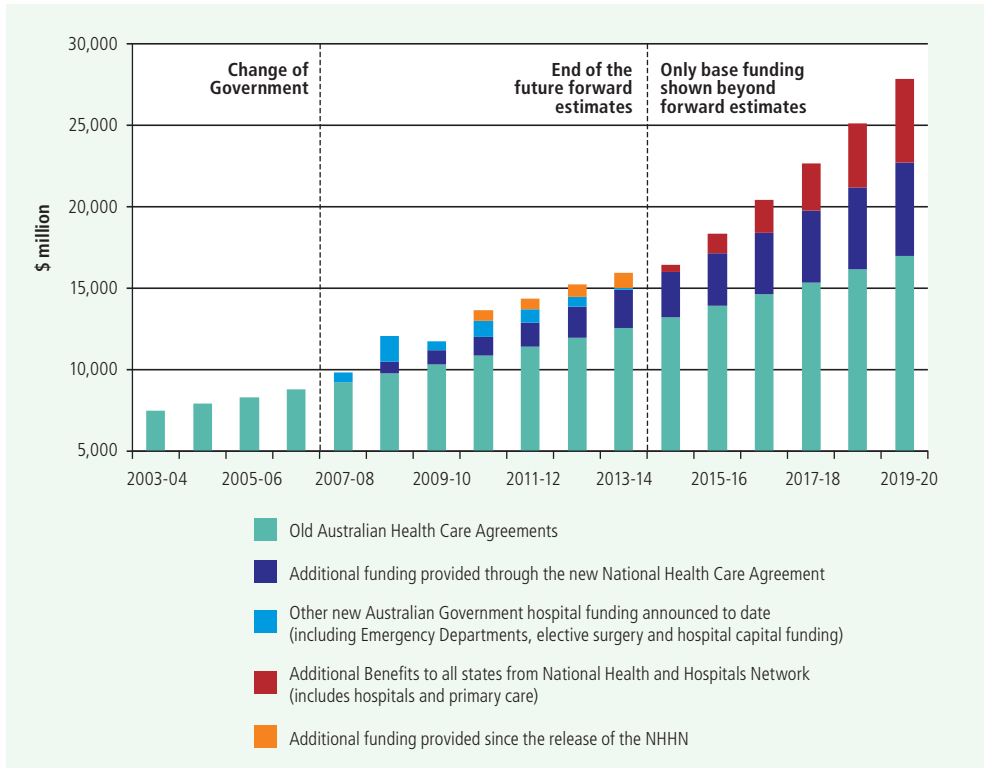
The measures outlined in this document, together with the structural reforms outlined in *A National Health and Hospitals Network for Australia's Future*, will be discussed with the states at the COAG meeting on April 19.

The additional investments outlined in this document make the Government's reform proposals an even better deal for the Australian community in every state and territory. On this basis, it is an even better deal for each state and territory government.

The Commonwealth is only willing to make these additional investments on the basis of structural reform of the health and hospital system – a national system that is funded nationally and run locally. As such, investments in each state are largely contingent on implementation of reform in each state to establish a National Health and Hospitals Network. As the Government has made clear in *A National Health and Hospitals Network for Australia's Future*, it reserves the right to seek a mandate from the Australian people to implement its National Health Reform Plan.

The Government looks forward to reaching agreement on these reforms at COAG, and to getting on with the job of building the National Health and Hospitals Network.

Figure 1: Australian Government additional health and hospital benefits from the National Health and Hospitals Network for all states



Source: Commonwealth Budget papers and Commonwealth Departments of Health and Ageing and Prime Minister and Cabinet analysis

CHAPTER ONE – HOSPITALS

Improving access to public hospital services

From 1 July 2010, the Government will invest \$1.2 billion to address key pressure points in the public hospital system. This includes:

- › \$500 million over four years to reduce emergency department waiting times to a maximum of four hours.
- › \$650 million over four years to reach a target of 95 per cent of elective surgeries within clinically recommended times, together with a guarantee of free rapid treatment in a public or private hospital if patients wait longer than is recommended.

These investments will deliver immediate improvements and help lift public hospitals to the new, higher national standards that will be a permanent feature of the National Health and Hospitals Network:

- › They will result in the equivalent of around 90,000 additional elective surgeries and around 1.2 million additional emergency department services.

The Government will introduce an annual Hospital Performance Report, rating every Local Hospital Network and every private hospital against new national performance standards. This will give Australians more information than ever before about the performance of their local hospital.

The Government will also give clinicians more of a voice in planning and service provision, and drive improvements in quality and safety, building on the improved clinician engagement that the Government's introduction of Local Hospital Networks will deliver.

Public Hospitals under pressure

While Australia's 762 public hospitals for the most part do a good job in providing high quality care to patients and are full of dedicated doctors, nurses and other staff, they are struggling to cope with growing patient demand.

- › Since 2001–02, at least 31 per cent of people attending emergency departments have waited longer than the recommended time for treatment.
- › Since 2002–03, around 16 per cent of elective surgery patients also waited longer than the recommended time for treatment.
- › Demand for and pressure on hospitals and health services will only intensify as a result of the ageing of our population and increasing rates of chronic disease.

Performance across the nation's public hospitals is also highly variable.

The 2009 *State of our Public Hospitals* report shows that for elective surgery, 88 per cent of patients were seen within clinically recommended times in New South Wales, compared to 83 per cent in Victoria, 85 per cent in Queensland, 81 per cent in South Australia, and 66 per cent in Tasmania.

For emergency departments, 76 per cent of patients in New South Wales were seen in clinically recommended times, compared to 63 per cent in Queensland, 61 per cent in Western Australia and South Australia, 60 per cent in Tasmania and 52 per cent in the Northern Territory.

Long waits in emergency departments

In 2007–08, there were over 7.1 million patients presenting to emergency departments in Australian public hospitals, a 5 per cent increase on the previous year.

When patients present to an emergency department, they are classified as belonging to one of five triage categories:

- › resuscitation – needing to be seen immediately (1 per cent of patients in 2007–08);
- › emergency – needing to be seen immediately within 10 minutes (9 per cent of patients);
- › urgent – needing to be seen immediately within 30 minutes (32 per cent of patients);
- › semi-urgent – needing to be seen immediately within 60 minutes (46 per cent of patients); or
- › non-urgent – needing to be seen immediately within 120 minutes (12 per cent of patients).

In 2007–08, 69 per cent of patients presenting to emergency departments were seen within the clinically recommended time.

Figure two shows the number and proportion of patients seen within clinically recommended times across the five triage categories in 2007–08.

Figure 2: Emergency department patients seen within clinically recommended times, by triage category, 2007–08

Triage category	Proportion seen within clinically recommended time (approximate)	Number of patients not seen within recommended time (approximate)
Category 1, Resuscitation (immediate treatment)	100%	0
Category 2, Emergency (within 10 minutes)	76%	112,373
Category 3, Urgent (within 30 minutes)	63%	639,247
Category 4, Semi-urgent (within 60 minutes)	66%	852,082
Category 5, Non-urgent (within 120 minutes)	87%	86,626
TOTAL	69%	1,690,328

Source: Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007–08*.

Note these figures only represent 78 per cent of the estimated 7.1 million accident and emergency presentations that occurred in 2007–08. Current data collection mechanisms do not extend to smaller hospitals.

Nearly a third of patients admitted to a bed from an emergency department wait more than eight hours between the time they arrive and when they are finally transferred to a bed in a ward. This is known as “access block”, and leads to a backlog of patients waiting for emergency department assessment and treatment.

The extent of access block is a good measure of hospital efficiency as well as how quickly seriously ill patients receive the care they need. Keeping patients moving through emergency departments and into further treatment elsewhere in the hospital is a critical indicator of the overall effectiveness of clinical care planning and management within hospitals.

For hospitals that report this level of data, approximately 468,000 patients waited more than eight hours in an emergency department before they were admitted to a hospital ward in 2007–08. For all hospitals, the estimated figure is 600,000 people.

States are working towards achieving a performance indicator introduced as part of the National Healthcare Agreement, of no patient having to wait more than eight hours from the time they come into an emergency department to the time they are admitted to the hospital, including treatment in the emergency department. Some states, such as Western Australia and South Australia, are already moving more quickly to try to achieve a four hour target on this critical measure of access to public hospital services.

Long waits for elective surgery

Elective surgery is surgery which does not need to be performed within 24 hours. In 2007–08, there were 1.8 million elective surgeries conducted in Australia, a 4.1 per cent increase on the previous year. Of these, 637,000 – around 35 per cent – were provided in public hospitals, with 565,501 provided in public hospitals where clinical urgency category information is collected.

The median waiting time for elective surgery for public hospital patients is 34 days. Almost one in six Australians on public hospital elective surgery wait lists are waiting longer than the clinically recommended times. In 2007–08, three percent of all elective surgery patients in public hospitals – around 17,000 people nationally – waited longer than a year before receiving their surgery.

Across the three elective surgery urgency categories, figure three shows that delays occur across all three categories and are worst for category 2 patients who are experiencing serious pain. In addition, many patients have difficulty getting onto public hospital waiting lists, suggesting these figures understate the problem.

Figure 3: Number and proportion of elective surgery patients seen within clinically recommended times, 2007–08

Urgency category	Description	Number of patients in this category	Proportion of patients within each category seen within clinically recommended times
Category 1	Has the potential to deteriorate quickly to the point that it may become an emergency – patients admitted within 30 days	175,305	89%
Category 2	Causing some pain, dysfunction or disability but not likely to deteriorate quickly or become an emergency – patients admitted within 90 days	220,546	74%
Category 3	Causing minimal or no pain, dysfunction or disability, unlikely to deteriorate quickly, and no potential to become an emergency – patients admitted within 365 days	169,650	92%

Source: Department of Health and Ageing, *The State of our Public Hospitals June 2009 Report*

Note: Patient numbers represent the number admitted from an elective surgery waiting list and may not equal total elective surgeries performed in public hospitals.

Safety, quality and clinical performance

The National Health and Hospitals Reform Commission indicated that adverse events result in approximately 4,550 unnecessary deaths a year and add a cost of around \$2 billion annually to the health budget.

The Australian Commission on Safety and Quality in Health Care was established by governments to lead and coordinate the safety and quality agenda in Australia’s health system, but clinical engagement is also fundamental to maintaining and improving clinical performance. In the Government’s consultations on health reform, many clinicians made it clear they do not feel they have the opportunity to be involved in decisions about the delivery of health services in their community. The devolution of responsibility for hospital management to Local Hospital Networks provides a critical basis for improved clinical performance, but more will need to be done.

What the Government has done so far to take the pressure off Australia's public hospitals

Since 2007, the Government has made major investments to improve access to emergency departments and elective surgery in our public hospitals.

To improve access to public hospitals, the Government is investing around \$64 billion over the next five years as part of the 2008 National Healthcare Agreement. The Government has also invested \$750 million to improve emergency department capacity – which has funded capital upgrades in 37 hospitals around the country and system improvements and enhancements in many others.

To improve access to elective surgery, beginning in 2008 the Government has invested \$600 million in an Elective Surgery Waiting List Reduction Plan:

- › Stage one of the Plan provided \$150 million for a blitz on elective surgery waiting lists, through which 41,000 additional elective surgery procedures were provided, exceeding the national target of an additional 25,000 procedures by 64 per cent.
- › Stage two of the Plan provided \$150 million for investments in improving elective surgery capacity at over 120 hospitals, including the purchase of medical and surgical equipment and the construction of operating theatres. The majority of these projects are expected to be completed by 30 June 2010. In the 18 months to June 2009, around 62,000 additional elective surgery procedures had been provided under stage one and two of the Plan.
- › Stage three of the Plan will provide \$300 million in reward payments for the achievement of stretch targets to increase the number of people receiving elective surgery and to reduce the number of people waiting too long for their surgery. Improved state performance between July 2009 and December 2010 is the focus for this stage of the plan.

Delivering better hospitals through the National Health and Hospitals Network

Through the establishment of the National Health and Hospitals Network the Government is proposing fundamental reforms to the way Australia's public hospitals are funded and run. These major structural changes to the Australian health system will help to deliver better health and better public hospitals – by supporting states to better meet demand, by making public hospitals more efficient over the long term, and by making hospitals more responsive to local community needs.

A key feature of the National Health and Hospitals Network is the introduction of new, higher national standards across the health system, including public hospitals. Strong national standards will help ensure consistent, high quality health care, and provide greater levels of transparency and information about the health system. This will increase accountability and drive improved outcomes.

In implementing these reforms, the Government recognises the importance of the continuing role that private hospitals and other private health care providers – along with private health insurance – play in delivering strong health outcomes.

Box 1: The National Health and Hospitals Network

- › For the first time, the Commonwealth Government will take majority funding responsibility for public hospitals – paying 60 per cent of the national efficient price for all public hospital services that Local Hospital Networks have agreed with states to provide.
- › This clarification of roles and responsibilities will create an incentive for the Commonwealth – as the majority funder of public hospital services – to keep people healthy and out of hospital, including by improving GP and primary health care services and the aged care system.
- › Local Hospital Networks will be responsible for making decisions on the day to day management and operations of public hospitals, with clear accountability for performance.
- › Under these new funding arrangements, the Commonwealth will meet its share of the efficient price of all public hospital services that Local Hospital Networks and states have agreed to provide. Through this, the Commonwealth will be exposed to the majority of growth in public hospital costs over time, including growth over and above the share of Goods and Services Tax (GST) the Commonwealth is allocating to a National Health and Hospital Network Fund.
- › The Commonwealth Government will pay Local Hospital Networks directly on the basis of an efficient price determined by a new national independent umpire.

New investments in hospitals under the National Health and Hospitals Network

Notwithstanding the Government's investments to date, emergency departments and access to elective surgery require further investment and reform. Growing demand means these two critical areas of public hospital service delivery remain under pressure.

To drive towards the new, higher national standards that will be a permanent feature of the National Health and Hospitals Network, the Government will make significant investments in the nation's public hospitals.

Four hour National Access Target for emergency departments

To improve timely treatment in emergency departments, for the first time, the Government will:

- › ensure that anyone presenting to a public hospital emergency department will be admitted to hospital, referred for treatment, or discharged within four hours, where it is clinically appropriate to do so.
- › invest \$500 million to assist emergency departments to meet this target – sufficient funding to support around 1.2 million additional emergency department services.

This four hour National Access Target will drive improved access to timely and safe emergency department services for patients. The four hour timeframe will commence upon a patient's arrival to an emergency department. This will ensure patients and families have the peace of mind of knowing that when they or a loved one need emergency department care, they will no longer have to spend all night sitting in the waiting room or waiting for a bed.

To help public hospitals meet this target, the Government will provide states with \$500 million as facilitation and reward funding.

From 1 July 2010, \$150 million in upfront payments will be provided on a population share basis to help with the costs of moving towards the four hour National Access Target. This investment will help provide the capital equipment, system planning and additional capacity elsewhere in hospitals that will be required to deliver immediate improvements and lift hospitals to the new, higher national standards that will be a permanent feature of the National Health and Hospitals Network.

The Government will also provide \$350 million in reward funding for states that meet or beat their targets. States will be required to spend any reward funding on health and hospitals, to continue investment in innovation and service delivery. This funding will be on top of ongoing recurrent funding for hospital services.

The target will be phased in over four years from 2011, to allow Local Hospital Networks and states to progressively reach the four hour target across the most urgent four triage categories. Triage category 5, non-urgent presentations, will be part of the target but will not drive reward payments, as this may encourage inappropriate usage of hospital emergency departments. The Government will make a range of other significant investments over time in the primary care system aimed at this category of patients.

Targets for emergency departments have been effective in improving waiting times and access to care internationally. In 2000, the UK Government introduced a target of no patients waiting longer than four hours in emergency departments from arrival to admission, transfer, or discharge. This was based on a series of incentive-backed intermediate targets provided by the UK Government. As a result, time spent in emergency departments has dramatically improved. In 2008–09, 98.1 per cent of patients spent less than four hours in an emergency department.

The Commonwealth – in consultation with clinicians and states – will develop a nationally consistent, clinically safe and appropriate definition of the four hour National Access Target. The target will not override the clinical judgement of doctors. This agreed definition will take into account circumstances in which it will be necessary, and clinically appropriate, for a patient to receive ongoing observation and care within an emergency department which may span beyond four hours.

Improving access to elective surgery

To improve access to elective surgery in public hospitals, the Government will:

- › Introduce a National Access Guarantee for Elective Surgery from 1 July 2012 under which free treatment in public or private hospitals will be rapidly provided if patients wait longer than the clinically recommended time for elective surgery.
- › Introduce a target for elective surgery, so that by 2014, 95 per cent of patients waiting for surgery should be treated within the clinically recommended time, up from the current level of 84 per cent.
- › Invest \$650 million to help hospitals achieve the target and National Access Guarantee. This funding will provide the equivalent of 90,000 additional elective surgeries across Australia.

A National Access Guarantee will give patients practical recourse if they have waited too long for their surgery. Any patient who has waited longer than the clinically recommended time will be fast-tracked for their surgery – including by scheduling their surgery at another hospital (at no cost to the patient) – to ensure that they do not wait significantly longer than the clinically recommended time for elective surgery.

These fast-tracked surgeries could be provided in public or private hospitals: the Government considers that Australia's private hospitals will have an important role to play in the delivery of this Guarantee. If a patient has already waited the clinically recommended time, category 1 patients will be treated within 5 days, category 2 patients within 15 days and category 3 patients within 45 days of the clinically recommended times, should it be safe to do so. Patients may choose to decline the offer should they not wish to be treated elsewhere.

To enforce the National Access Guarantee, states will be required to identify when patients are not being treated on time, and work with patients and Local Hospital Networks to get surgery offered to these patients. States' delivery of the guarantee will be monitored by the new independent reporting function and Local Hospital Networks will be required to publicly report on their performance. There will be a single national hotline for people to call if they want to enforce the guarantee.

In drawing on the resources of both the public and private sectors, the National Access Guarantee will get the best out of the entire hospital system, and recognise the critical role of private hospitals in relation to elective surgery.

Under the target for elective surgery, 95 per cent of patients waiting for surgery will be treated within the clinically recommended time by 2014, up from 84 per cent currently. Appropriate clinical standards will be stringently enforced to ensure guarantees and targets are not met at the expense of quality of care. The introduction of national targets will be staged to allow for graduated improvements each year. The interim targets will build on the targets which were set for the Elective Surgery Waiting List Reduction Plan. The Commonwealth will also work with the states to measure the time between referral and getting on the waiting list, with the aim of incorporating this into the measurement of patient waiting times.

For a patient, this means that there is a 95 per cent chance that they will receive their elective surgery within the timeframes recommended by their doctor. For the small minority that do not, they will have a clear and short timeframe for their surgery to be completed, unlike now where they may have to wait months for their surgery and may have it frequently cancelled.

The Government will support this target and National Access Guarantee with \$350 million in financial rewards for states that meet or beat their targets. States will be required to spend any reward funding on health and hospitals, to continue investment in innovation and service delivery. This funding will be on top of ongoing recurrent funding for hospital services.

Starting on July 1 this year \$300 million in upfront payments will be provided on a population share basis to help with the costs of delivering additional surgery services, to help clear waiting lists, through the provision of around 43,000 additional services. This investment will help lift the hospital system to new, higher national standards.

This measure builds upon the recommendation of the National Health and Hospitals Reform Commission to develop and adopt national access targets, with funding linked to meeting or improving performance towards the targets.

Transparent Hospital Performance Reports

The Government will introduce clear and transparent reporting on the performance of every Local Hospital Network, and the hospitals within it, and every private hospital through annual Hospital Performance Reports. This will show how Local Hospital Networks perform against new national standards and other performance indicators, including on:

- › emergency department waiting times;
- › elective surgery waiting times;
- › adverse events in hospitals;
- › quality of care (for instance through reporting on re-admission rates);
- › patient satisfaction; and
- › financial management.

Hospital Performance Reports will provide Australians with more information than ever before about the performance of their Local Hospital Networks, and the hospitals within it, and on every private hospital. This information will also help health care providers promote a culture of continuous improvement.

Clinician Engagement

Providing a platform for clinicians to encourage the use of evidence based medicine, and help shape nationally appropriate quality and safety standards, is a critical component of improving health outcomes and encouraging best practice. The National Health and Hospitals Network will build on other measures to improve hospital standards through increased levels of clinical engagement.

The corporate governance of the Local Hospital Networks will include clinicians on the Governing Council, and Local Hospital Networks will work with local clinicians to incorporate their views, especially on quality and safety, into the day to day operation of the hospitals. The Government will also support local clinicians to turn national clinical guidance into local practice, and guide improved safety and quality outcomes for the Local Hospital Network.

The Government will introduce measures to improve the evidence base available to clinicians, allowing for more effective and efficient clinical care.

Specific reform measures will be announced by the Government shortly, building on current state and Commonwealth efforts in clinical governance, strengthening clinical engagement and improving quality of care.

Further reforms to help take the pressure off public hospitals

Through the reforms announced elsewhere in this document, the Government will also work to take the pressure off public hospitals by:

- › transforming how patients with chronic disease are treated through coordinated care for patients with diabetes;
- › improving Australians' access to GP and better integrated primary health care; and
- › increasing the capacity of the aged care sector to reduce the number of older Australians waiting in hospital beds for an aged care bed.

The Government's major investments in our health workforce will also help increase access to hospital services by increasing the capacity of our health and hospital system.

How the Government will implement these reforms

From 1 July 2010:

- › The Government will pay \$300 million in upfront facilitation payments to states to conduct an elective surgery blitz before the commencement of elective surgery targets.
- › The Government will provide \$150 million upfront payments to states to help with the costs of moving towards the National Access Target for emergency departments.
- › The first *Hospital Performance Report* will be released during 2010–11.

From 1 January 2011:

- › The four hour emergency department National Access Target would commence with triage category one.

From 1 July 2011:

- › The elective surgery target will commence. Targets will be staged to allow for graduated improvements each year, up to a final target of 95 per cent of all elective surgeries to be achieved by 2014. Performance will be assessed and reported every six months, with reward funding provided after good performance is demonstrated.
- › The Government will commence payment of \$350 million in reward funding for the elective surgery target.
- › The Government will commence payment of \$350 million in reward funding for the four hour National Access Target for emergency departments.

From 1 July 2012:

- › Patients will be entitled to the National Access Guarantee for elective surgery.
- › The four hour emergency department National Access Target would be extended to triage category two.

From 1 July 2013 the four hour emergency department National Access Target would be extended to triage category three.

From 1 July 2014 the four hour emergency department National Access Target would be extended to triage category four.

CHAPTER TWO: GP AND PRIMARY HEALTH CARE

Improving access to GP and primary health care to keep people healthy in the community

The Government will make a major investment in GP and primary health care, to improve access to GP services, deliver better health care in the community and take the pressure off our hospitals.

The Government will:

- › Establish independent primary health care organisations across Australia with strong links to local communities and health professionals – to provide better services, improve access to care and drive integration across GP and primary health care services.
- › Transform the way Australians with long term illness are treated with a \$436 million investment in coordinated care for Australians living with diabetes.
- › Invest \$339 million to double the number of GP training places (as described in chapter three).
- › Deliver better primary health care services for aged care (as described in chapter four).

These reforms will build on the Government's commitment to take full policy and funding responsibility for GP and primary health care, meaning that one level of Government will have a clear responsibility for improving services in the community and taking pressure off hospitals.

Better GP and primary health care is needed to help take the pressure off our hospitals

GP and primary health care is the frontline of Australia's health system. More than 85 per cent of Australians see a GP at least once a year. Medicare subsidises more than 110 million visits to GPs each year. While Australia's GPs and other primary health care professionals serve the community well, they could be better supported to meet the health care needs of our growing and ageing population.

There is a range of challenges to GP and primary health care being more effective in treating patients in the community to keep them healthy and out of hospital. These include:

- › fragmentation across GP and primary health care services, which is often reinforced by funding arrangements that do not support coordination between services or ongoing care over a long period of time;
- › the large and growing burden of chronic disease; and
- › constraints on the health workforce, particularly in rural and remote areas.

These contribute to the high rate of hospitalisation in Australia compared to the OECD average and countries such as the United States, Canada and New Zealand (as shown in figure one below). A large proportion of these hospitalisations could be avoided. The Australian Institute of Health and Welfare has estimated that potentially preventable hospitalisations represented 9.3 per cent of all hospitalisations in 2007–08. This equates to around 441,000 potentially preventable hospitalisations in public hospitals. The average cost of a hospitalisation in a public hospital is around \$4,230 per episode of care.

Figure 4: Hospital discharges per 1,000 population, selected countries, 2007



Source: Organisation for Economic Cooperation and Development, *Health at a Glance 2009*.
Note – the source uses a mix of 2006 and 2007 data.

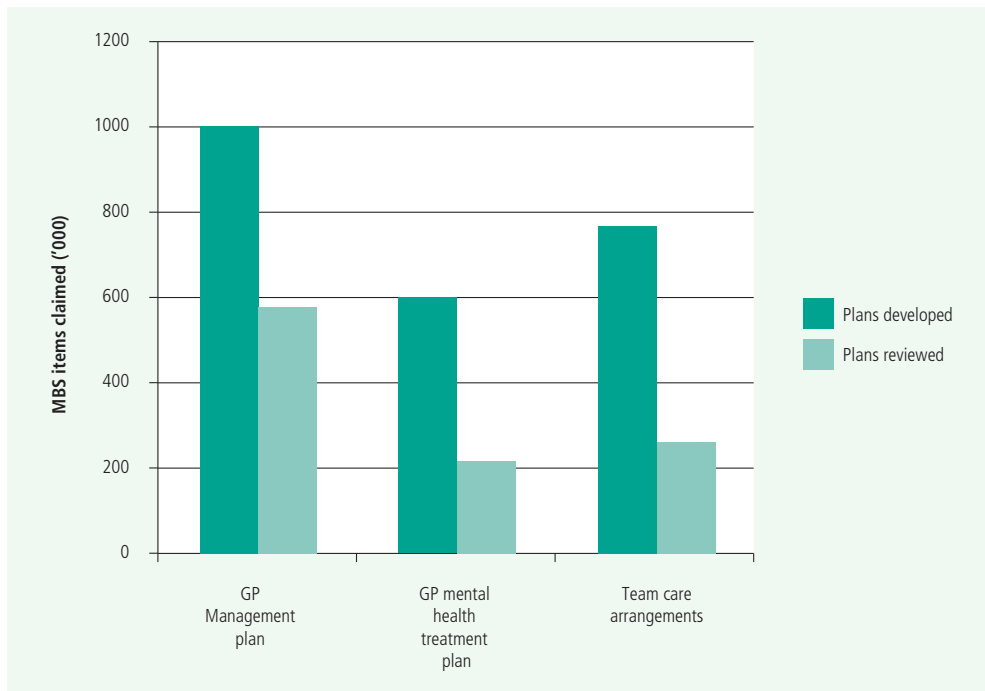
Fragmented GP and primary health care, including through funding arrangements that do not support coordinated care

Increasing rates of chronic disease, together with an ageing population, mean that an increasing number of patients will require greater levels of support and care into the future. To meet the increasingly complex needs of patients, GP and primary health care services will need to be provided in a more integrated and accessible fashion. Submissions to the draft *National Primary Health Care Strategy*, especially from consumer groups, consistently stressed the need for better integration of primary health care services.

Currently, there is limited planning for GP and primary health care services – including poor identification of and response to gaps in services. The Medicare Benefits Schedule (MBS) has long been the principal means of funding of GP and primary care services in Australians, but it has limited impact in encouraging GPs and primary health care professionals to work together or with other health providers such as hospitals and aged care services.

Funding arrangements under the MBS support a focus on addressing symptoms when patients are ill, rather than keeping people well. This meets the needs of many Australians, but is not always suited to the increasing number of patients requiring ongoing and coordinated care. For example, figure five shows that many patients with chronic disease have received care plans from their GPs, but this has not followed through into ongoing engagement and review of these plans.

Figure 5: Development and review of care plans by GPs, 2008–09



Source: Medicare Australia, *Item reports – items 721, 723, 725, 727, 2710, 2712, 2008–09.*

The large and growing burden of chronic disease

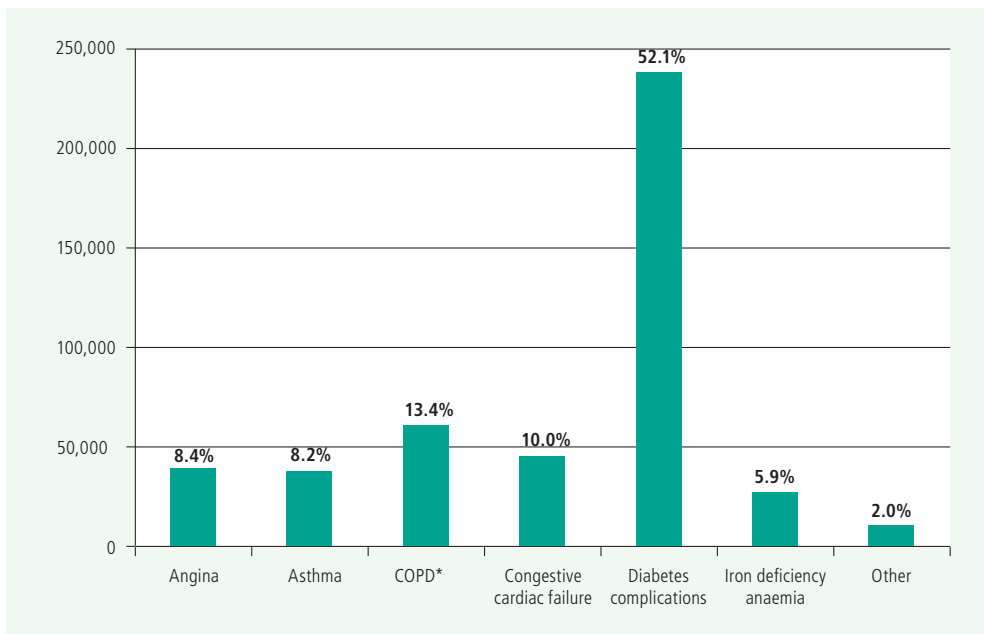
Chronic diseases like diabetes represent a big challenge for our health system:

- ▶ Chronic diseases are estimated to be responsible for more than 80 per cent of the burden of disease and injury in Australia.
- ▶ More than half of all GP consultations are with people with a chronic condition like heart disease, cancer, neurological illness, mental disorders and diabetes.

The need for more integrated GP and primary health care is most pressing for patients with chronic disease. For instance, patients with diabetes often need care from multiple health professionals, including GPs, specialists (such as endocrinologists), dietitians and podiatrists. Usually this range of health professionals is not located in the one place.

Of the estimated 731,000 potentially preventable hospital admissions in 2007–08 in public and private hospitals, around 237,000 (32 per cent) were related to complications from diabetes that could have been avoided through better management. For those avoidable admissions which relate to chronic conditions, figure six shows that the proportion linked to complications from diabetes is more than 50 per cent.

Figure 6: Potentially preventable hospitalisations for chronic conditions, 2007–08



* – chronic obstructive pulmonary disease.

Source: Australian Institute of Health and Welfare, *Australian Hospital Statistics 2007–08, 2009*.

The burden of chronic disease is projected to dramatically increase into the future. By 2032–33 combined spending on cardiovascular and respiratory diseases is projected to be around \$40 billion annually, while spending on type 2 diabetes is projected to increase by 520 per cent between 2002–03 and 2032–33 (resulting from factors such as ageing, increase in obesity and in treatment and services).

Currently nearly one million Australians have diabetes. This number is projected to triple over the period 2003 to 2033, driving a projected five-fold real increase in spending on diabetes care over this period. The arrangements that are in place today are unlikely to cope with this projected increase in the number of patients with diabetes. Diabetes can and should be well managed out of hospital, yet many patients with type 2 diabetes experience poorly managed care. This contributes to avoidable hospital admissions, poor health outcomes and a reduced quality of life. Divisions of General Practice have played some role in filling access gaps and better coordinating care, but often lack the resources or the breadth of scope to be able to drive the major change needed.

Increasing rates of chronic disease such as diabetes present challenges to the sustainability of our health and hospital system. They also present major challenges to our economy: the financial cost of type 2 diabetes is estimated by Diabetes Australia to be \$10.3 billion per year, including direct health system costs, carer costs and lost productivity and workforce participation.

Workforce constraints

Workforce shortages and poor distribution of the health workforce limit access to GP and primary health care services. These shortages particularly affect regional and rural areas where many Australians find it difficult to access basic health services. Chapter three provides further details on current workforce constraints impacting on the delivery of primary health care services.

What the Government has done so far

Since 2007, the Government has enhanced GP and primary health care by funding 36 GP Super Clinics that are being built across the country. These GP Super Clinics will provide comprehensive services in a single location, bringing together GPs, nurses, visiting medical specialists, allied health professionals and other health care providers.

Over the past two years, the Government has also invested in critical areas of need to ensure that more Australians will be able to access GP and primary health care services. In 2008, the Government increased GP training places by 35 per cent.

To improve access to GP and primary health care services for Australians in rural and remote areas, the Government established a national Rural and Remote Health Infrastructure Program, which has delivered \$28 million for 137 projects since 2008. In addition some 500 communities and 2,400 doctors in rural Australia will become eligible for financial support for the first time, as part of the Government's overhaul of rural and remote workforce incentives.

To ensure that the skills of our nursing workforce are better recognised, the Government is delivering MBS and Pharmaceutical Benefits Scheme (PBS) access to nurse practitioners for the first time. This will help free up doctors to focus on matters that require their level of skill and expertise. In addition, the Government has invested \$120.5 million in improving maternity services so that more Australian women are provided with more choice in their maternity care, including access of eligible midwives to MBS benefits and PBS medicines.

To set out a path for primary care reform into the future, the Government has also developed a draft *National Primary Health Care Strategy*.

Improvements for primary health care under the National Health and Hospitals Network

Increasingly over the last decade, hospitals have tended to operate as a safety net that some patients have turned to in the absence of readily accessible or affordable GP services. As part of establishing the National Health and Hospitals Network, the Commonwealth Government will take full funding and policy responsibility for GP and primary health care – and for the first time shoulder the majority of the financial burden for hospitals.

Making a single level of Government responsible for both the majority of the cost of a visit to the hospital and all of primary care will put in place a clear and powerful financial incentive to take pressure off hospitals.

With its majority funding responsibility for hospitals, the Commonwealth will now have a financial interest in ensuring that people are treated through high quality but less expensive primary care services, rather than being shunted into expensive hospital services.

This will reduce cost shifting and provide more convenient care for patients. It will also provide a critical platform for making these services better coordinated and more responsive to the needs of patients.

Taking responsibility for GP and primary health care services provides a strong foundation for reforms to these services. It provides a platform for integrating the current patchwork of GP and primary health care services. It will help ensure patients are cared for in the most appropriate and efficient setting.

It will also enable greater consistency in the delivery of primary health care services, and provide scope through primary health care organisations to foster planning and coordination at the local community level. More broadly, the new arrangements will provide opportunities to bring state community health services and Commonwealth-funded services together in the one setting for integrated primary health care.

New investments in GP and primary health care

The Government will build on its takeover of full funding and policy responsibility for primary health care with a significant investment in GP and primary health care services.

Together, these changes will deliver more integrated care for patients with diabetes and improve access to high quality GP and primary health care services. Improving care in the community will help keep patients healthy and out of hospital. This will take the pressure off our public hospitals, and help ensure the financial sustainability of our health and hospital system.

New primary health care organisations

The Government will support the establishment of primary health care organisations across Australia. These organisations will improve the delivery of primary health care services at the local level – for example, through facilitating access to allied health services for patients with chronic conditions. By coordinating these kinds of services, primary health care organisations will ensure local primary care is better integrated and more responsive to the needs and priorities of patients and communities.

Primary health care organisations will be independent legal entities (not government bodies) with strong links to local communities, health professionals and service providers, including GPs, allied health professionals and Aboriginal Medical Services. They will be integral to delivering a National Health and Hospitals Network which is nationally funded, but locally run. It is expected that the first primary health care organisations will commence operations by mid 2011 with the rest to be rolled out by mid 2012.

They will operate with strong local governance, including broad community and health professional representation, as well as business and management expertise. Strong clinical leadership will be a key feature, and their role will be to support clinicians, not to get involved in clinical decision making about individual patients.

Separate Local Hospital Networks and primary health care organisations will enable the primary health care sector to be strengthened over time, providing a platform for primary care to be firmly entrenched at the core of the health system. International evidence shows that health systems with better primary health care achieve better health outcomes and better value for money. Australia has been lagging on this issue for too long.

To formally enhance cooperation between hospitals and primary care services in a community, primary health care organisations will be expected to have some common membership of governance structures with Local Hospital Networks, and vice versa. In addition, primary health care organisations' service agreements will require them to work closely with Local Hospital Networks, and vice versa.

Primary health care organisations will be responsible for a range of functions aimed at making it easier for patients to navigate the local health care system and to provide more integrated care. For example, they will:

- › Facilitate allied health care and other support for people with chronic conditions, as identified in personalised care plans prepared by GPs.
- › Work with local health care professionals to ensure services cooperate and collaborate with each other so that patients can easily and conveniently access the full range of services they need.
- › Identify groups of people missing out on GP and primary health care, or services that a local area needs, and better target services to respond to these gaps.
- › Work with Local Hospital Networks to assist with patients' transition out of hospital, and where relevant into aged care.
- › Deliver health promotion and preventive health programs targeted to risk factors in communities in cooperation with the Australian National Preventive Health Agency, once it is established.

For instance, a local primary health care organisation, in consultation with local GPs, might identify that there are a large number of diabetics in a particular area – and organise a roster of allied health professionals such as nutritionists and diabetic educators to provide sessional services to different GP clinics in that area.

The planning and management of an individual patient's care will remain the responsibility of the GP – primary health care organisations will not change this. Rather, by identifying and helping to fill gaps in service delivery, primary health care organisations will be able to complement services provided by GPs. They could also ensure that when a patient leaves hospital, they have a usual GP who they can go to for follow up care, and if they don't, put them in touch with one.

This will be of particular benefit for patients with chronic disease. A core function of primary health care organisations will be to enhance the capacity of GPs to manage the care of people with chronic conditions, by providing them with a complementary array of services, so that a patient's experience is less fragmented and more satisfactory.

Primary health care organisations will work with local GPs and Local Hospital Networks to improve patient care and quality and safety of health services. Primary health care organisations will also work closely with practitioners and services in the primary health care, hospital, aged care and Indigenous health sectors to support greater collaboration between service providers.

Over time, primary health care organisations will improve the delivery of and access to primary health care services at the local level:

- › There will be fewer gaps in services, particularly for patients with chronic conditions and special needs.
- › Patients will find it easier to navigate the local health system to find the services they need. There will be smoother transitions between service providers and greater coordination of services.

Subject to agreement with the states, primary health care organisations may play an increasing role in delivering services currently funded by states but set to transfer to the Commonwealth through the Government's reforms.

Over time, in conjunction with the Australian National Preventative Health Agency, they will also drive an increased focus on local community based approaches to preventive health, by identifying and managing risk factors in local communities. For instance, a primary health care organisation might identify high rates of alcohol misuse within a community, and work with local GPs and other health professionals, as well as governments, to develop measures to address this.

In addition, as part of the performance and accountability arrangements built into the National Health and Hospitals Network, the Government will develop a Healthy Communities Report for each primary health care organisation's local area.

This Report will include, on a nationally consistent basis, local and regional area information covering:

- › preventive health risk factors and other measures of community health and wellbeing;
- › access to GP services and out of hours GP care; and
- › the extent to which the health system is working in a coordinated way, for example through the number of avoidable hospital admissions and trends in this information over time.

The Government will work with GP and primary health care stakeholders, including clinicians, local government, states, academics, consumer groups and the Australian National Preventive Health Agency (once established), to develop the Report structure, and to identify what data is already available and what will need to be developed over time.

The importance of reporting on the performance of the health system, as a driver of improvement and innovation, was highlighted by the NHHRC.

Where possible, primary health care organisations will be drawn from those Divisions of General Practice that have the capacity to take on the roles and functions expected under the new arrangements. A key principle will be to minimise disruption to health practitioners and service providers so that clinical care to patients is not affected during the transition or establishment phase.

Coordinated care for patients with diabetes

To respond to the rapidly rising incidence of chronic disease, the government will invest \$436 million to transform the way patients with chronic disease are treated – beginning with the nearly one million Australians who suffer from diabetes.

For the first time, patients diagnosed with diabetes will have the option of enrolling with a GP practice of their choice to receive high quality coordinated care and help them access a range of additional services (such as a dietitian or podiatrist).

This will help patients to maintain and improve their health, with GP practices for the first time being rewarded for meeting performance benchmarks. It will reduce the costs associated with managing complications of diabetes and of unnecessary hospital admissions.

Patients will have the choice to enrol with a GP practice that will:

- ▶ become responsible for managing their care, including by developing a personalised care plan;
- ▶ help organise access to the additional services they need, such as care from a dietitian or podiatrist, as set out in their personalised care plan; and
- ▶ be paid, in part, on the basis of their performance in keeping their patients healthy and out of hospital.

This will benefit patients by ensuring that:

- › their GP is supported to manage their condition and keep them healthy over time, rather than just treating the symptoms in front of them;
- › they have access to the services they need to manage their condition; and
- › their care, which will often involve multiple health professionals, is coordinated to meet their needs.

This measure is particularly important for improving the health of Indigenous Australians. Indigenous Australians reported diabetes or high blood sugar levels at triple the rate of non-Indigenous Australians.

This means a single practice will be responsible for ensuring that patients who choose to enrol are able to access services from a wide range of health professionals. GP practices will help organise access to the additional services patients need, such as care from a dietitian or podiatrist, as set out in their personalised care plan. Practices will be able to use the new arrangements and Government funding flexibly to coordinate the full range of services that patients need.

Importantly, patients will continue to be able to see any GP of their choice, for example if they are on holiday in a different city.

Providing patients with a complex condition like diabetes with the option of enrolling with a single primary care service was recommended by both the NHHRC and the draft *National Primary Health Care Strategy*.

The Government expects that:

- › more than 4,300 general practices, covering around 60 per cent of all general practices, will sign on to the program by 2012–13, its first year of operation; and
- › approximately 260,000 patients with diabetes will be enrolled in a personalised care program by 2013–14.

The Government will work with patient and health consumer representatives and key primary health care groups, including GPs, nurses and allied health providers, on detailed implementation arrangements for this policy. This includes the development of a performance framework.

Based on this performance framework, practices will stand to be rewarded if their patient's health improves. GPs will be paid to help patients manage their condition over time, and ensure they can access the kinds of care they need. The Government will provide:

- › payments of around \$1,200 a year on average for every enrolled patient – to cover the costs of the patient's day to day GP primary health care and additional services; and
- › payments of around \$10,800 a year for the average general practice, paid in part on the basis of performance in providing better care and keeping patients healthy.

These reforms will be supported by mechanisms to support compliance and provide necessary checks and accountability for funding.

The Government intends to move over time to include other chronic diseases in these arrangements, where this is clinically appropriate, and as early evidence from this initiative becomes available.

Investing to grow the GP and primary health care workforce

To improve access to GP and primary health care, the Government is investing to train more doctors, nurses and allied health professionals, and make the most of the skills and dedication of our existing workforce. The Government will deliver:

- › 1,375 more GPs practising or in training by 2013, and 5,500 new GPs or GPs undergoing training in the next decade (\$339 million);
- › 975 places each year for junior doctors to experience a career in general practice during their postgraduate training period (\$148 million);
- › 400 more clinical training scholarships over four years for allied health students in rural and regional areas (\$6 million); and
- › a rural locum scheme to support 400 allied health professionals, to help them access ongoing education and holiday cover (\$5 million).

These measures are discussed further in chapter three.

Better GP and primary health care for people in aged care

As will be discussed further in chapter four, the Government will invest \$96 million over the next four years to:

- › increase financial incentives to GPs to provide more services to Australians receiving aged care; and
- › provide flexible funding to target gaps in primary health care for older Australians, in order to provide older Australians with care in their place of residence.

This will improve older Australians' access to care, and help reduce avoidable hospital admissions.

How the Government will implement this reform:

Primary health care organisations

The Commonwealth will work closely with Divisions of General Practice Network, states and other stakeholders to finalise the implementation arrangements.

It is expected that primary health care organisations will be established in two phases:

- › The first group of primary health care organisations will commence operations in mid 2011.
- › The remaining primary health care organisations will commence operations by mid 2012.

Coordinated care for patients with diabetes

In consultation with primary health care stakeholders, initial work in 2010–11 and 2011–12 will be undertaken to develop the new program arrangements, including patient identification and voluntary enrolment processes and payments, performance and monitoring systems.

In 2012–13, it is expected that more than 4,300 GP practices, covering around 60 per cent of all GP practices, will sign on to the program with approximately 260,000 patients with diabetes enrolled by 2013–14.

CHAPTER THREE – WORKFORCE

Building Australia's health workforce to deliver better health and better hospitals

The Government will make a \$643 million investment to ensure our health workforce meets the needs of Australians today, and the growing demands of the future.

This investment will train more doctors, provide clinical training pathways for nursing students and support nurses and allied health professionals working in rural Australia.

The Government will deliver:

- › 1,375 more general practitioners (GPs) practising or in training by 2013, and 5,500 new GPs or GPs undergoing training over the next decade (\$339 million);
- › 975 places each year for junior doctors to experience a career in general practice during their postgraduate training period (\$148 million);
- › 680 more specialist doctors over the next decade (\$145 million);
- › 1,000 extra clinical training scholarships for allied health students over the next decade (\$6 million);
- › for the first time, support for up to 1,000 allied health professionals over the next decade to take leave, including to access professional development courses to keep their skills up to date (\$5 million).

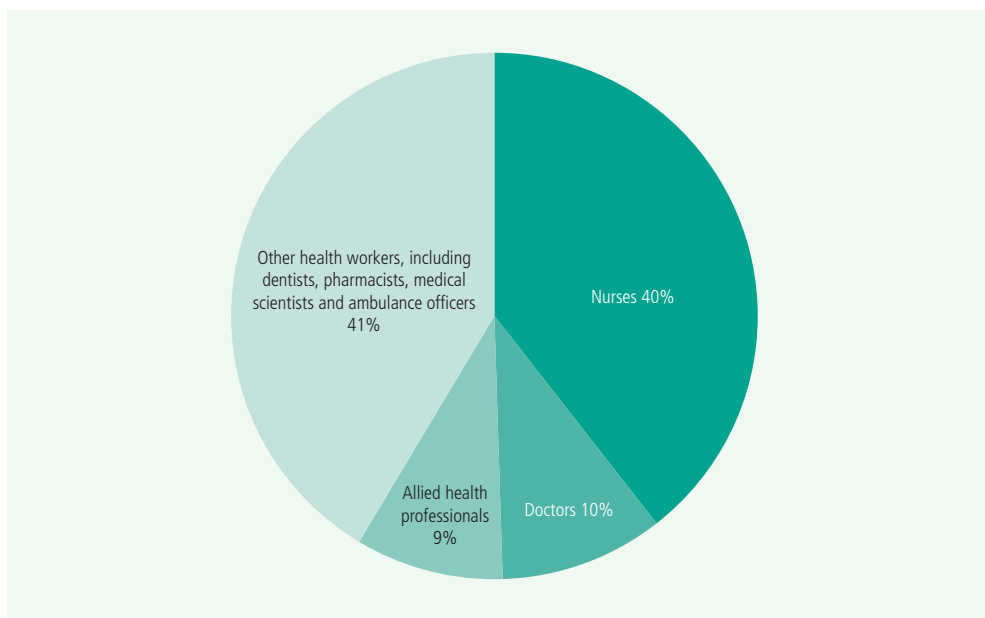
These reforms build on the Government's commitment to fund 60 per cent of the costs of training undertaken in public hospitals, which will make the Commonwealth Government the majority funder of training for future doctors, nurses and allied health professionals.

Australia's health workforce

The doctors, nurses and other health professionals who make up our health workforce are the lifeblood of the health system, and will be central to the delivery of the National Health and Hospitals Network. Almost 600,000 Australians are employed in health service occupations, which represent 5.8 per cent of Australia's total workforce. As figure seven shows, the Australian Institute of Health and Welfare reports that this broadly comprises:

- › 233,500 nurses;
- › 59,500 doctors;
- › 53,600 allied health professionals; and
- › about 245,000 other health workers, including dentists, pharmacists, medical scientists and ambulance officers.

Figure 7: Australians employed in health service occupations



Source: Australian Institute of Health and Welfare, *Australia's Health 2008, 2009*.

Current workforce constraints

Our health workforce delivers health care that serves most Australians well. But large parts of Australia are experiencing workforce shortages. Many of the problems with our health system today arise because there are not enough health professionals to meet the demand for services, particularly in rural and regional Australia. There is also room to improve the way we focus the skills and training of our workforce to where they are most required.

In 2007 it was estimated that 59 per cent of Australians live in an area with a shortage of available doctors. Both the NHHRC and the draft *National Primary Health Care Strategy* noted overall shortages across a range of the nursing, medical and allied health professions.

These constraints put pressure on our hard working doctors, nurses and health professionals. They contribute to long waits for emergency department and elective surgery services and contribute to difficulties accessing GP and primary health care services, especially for patients who are:

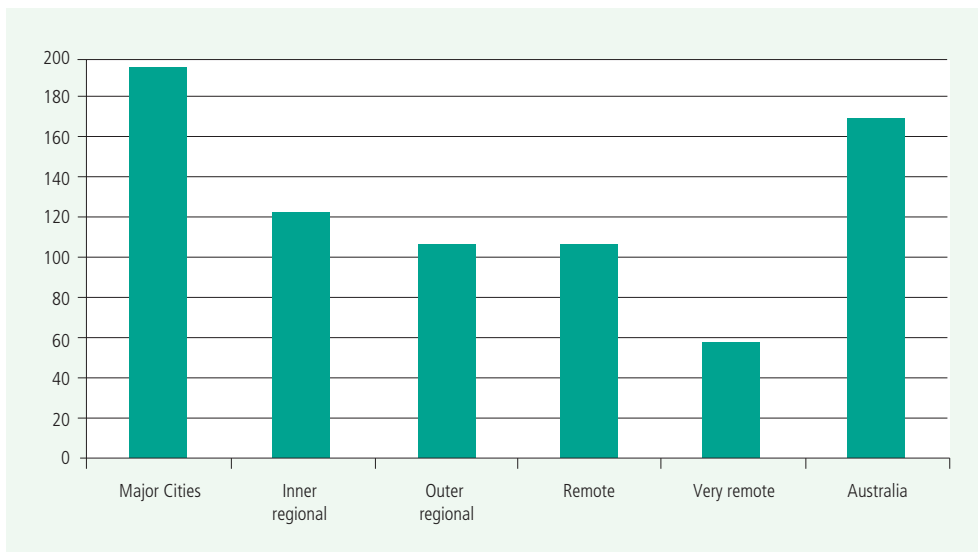
- › from rural and regional areas;
- › suffering from chronic and complex conditions; or
- › in need of care after hours.

Because they cannot always access GPs and primary health care, many of these patients end up in hospital, when this could have been avoided with better care in the community. GP and primary health care workforce shortages thus contribute to Australia having a higher hospitalisation rate than in other advanced countries. These challenges in turn put extra pressure on the dedicated health professionals currently working hard to deliver services across Australia.

Workforce constraints in regional and rural Australia

Workforce shortages are most acute outside Australia's major cities. Figure eight shows the number of GPs per 100,000 head of population varies from under 60 in very remote Australia through to almost 200 GPs per 100,000 people in major cities.

Figure 8: GPs per 100,000 population, 2006



Source: Australian Institute of Health and Welfare, *Health and Community Services Workforce 2006*, 2009.

The majority of allied health practitioners also work in metropolitan locations. Only 64 workers per 100,000 population work in very remote areas of Australia, compared to 354 per 100,000 in major cities. In addition, most rural health service providers employ relatively small numbers of staff. This makes it harder for rural allied health professionals – along with other rural health professionals – to take leave, or to pursue training and professional development.

These workforce shortages in rural and remote areas are compounded by the logistical challenge of servicing highly dispersed populations over wide geographic areas.

Increasing demand into the future

Increasing rates of long term illness, along with our ageing and growing population, are driving increasing demand for health and hospital services and will continue to do so into the future. Without greater investment in our health workforce, we will not have the future health workforce to meet this demand.

- › Medicare subsidises more than 110 million visits to GPs each year. To simply maintain this level of service Australia will need a further 3,000 GPs over the next decade.
- › Estimates from reports prepared by the Australian Medical Workforce Advisory Committee indicate there will be a shortage of around 1,280 specialist doctors by 2020.

Nursing shortages are a result of underinvestment and poor retention rates. Each year around 12,000 nurses leave the profession. Nursing courses have a 20 per cent dropout rate, much higher than the two per cent dropout rate for medical courses. As a result of these factors, Australia is estimated to need an extra 6,000 nurses each year to meet current and projected demand through to 2025. It is thus essential that we work to attract new nurses and retain more nurses currently in the health system.

An ageing workforce, and long lead times to train new health professionals

Workforce constraints are exacerbated by the ageing of our health workforce:

- › The average age of nurses is 44 years old, while more than a third of GPs are aged 55 and over.
- › More than a quarter of the whole medical workforce is aged 55 and over.

The long lead times involved in growing our health workforce present a further challenge. It can take up to 15 years to fully train a medical specialist and two to six years to train other professionals such as nurses. With the ageing of the current health workforce, the supply of experienced supervisors and trainers is constrained. This makes building the capacity to provide clinical training to undergraduate and postgraduate students all the more important.

The need for expanded clinical training capacity

Medical graduate numbers are increasing. In 2008 Australia had 2,137 medical graduates. In 2014 there will be over 3,100 domestic and 670 international full-fee paying graduates. As these students progress through their training, there will be added pressure on training capacity at each stage – undergraduate, prevocational (the intern year between undergraduate and specialist training) and vocational training (when training to be a specialist).

Clinical training capacity across the health system will need to be expanded. This will ensure students get access to the high quality clinical training that they require. This training will also need to be across the full scope of practice that would be expected of a future independent practitioner. To achieve this, training needs to be delivered in a range of settings that match future practice requirements. These should go beyond the traditional teaching hospitals into private and community based settings to deliver the training required for future service delivery.

The private health care sector has not traditionally provided a significant portion of the training of future health professionals. With a significant amount of health service delivery occurring in this sector – for example, over 50 per cent of elective surgery now takes place in private hospitals – and increasing demand for quality clinical training to support the training of an increasing number of health professionals, it is important that training in the private sector be encouraged and supported.

In future years, there will also need to be more specialist training places available to enable the current numbers of medical students to pursue careers in specialist disciplines.

What the Government has done so far to build Australia's health workforce

The Government has made unprecedented investments in Australia's health workforce since 2007. This includes \$1.1 billion as part of the November 2008 Council of Australian Governments (COAG) agreement to train more doctors, nurses and allied health professionals. This provided:

- › \$497 million to expand undergraduate clinical training places for undergraduate medical, nursing and allied health students;
- › \$28 million to help train approximately 18,000 nurse supervisors, 5,000 allied health and VET supervisors, and 7,000 medical supervisors;
- › 212 additional ongoing GP training places per annum – a 35 per cent increase on the limit imposed since 2004; and
- › 73 additional specialist training places in the private sector each year.

The Government has created 1,134 more ongoing university nursing places, and 200 more vocational training places to train more enrolled nurses, since November 2007. In addition, the Government is introducing reforms to higher education as a result of the Bradley review. These reforms will give universities greater capacity to choose the range and mix of courses they offer, including in health disciplines. They will reduce the constraints on universities' provision of courses in health disciplines like nursing, physiotherapy and occupational therapy.

As part of a \$134 million investment, around 2,400 doctors in rural Australia will, for the first time, become eligible for financial support to stay in rural and remote areas. This will help some 500 communities address the challenges in accessing basic health care services faced by Australians living in regional and rural areas.

Alongside these investments, the Government established Health Workforce Australia, Australia's first health workforce planning agency to better plan for our future health workforce needs. For the first time, a single national body will be responsible for planning the long term workforce requirements of our health and hospital system.

The Government has also put in place reforms to make smarter use of our health workforce by providing nurse practitioners and midwives with access to MBS benefits and the Pharmaceutical Benefits Scheme.

In partnership with states, the Government is implementing a National Registration and Accreditation Scheme to support registered health and medical practitioners, starting on 1 July 2010. A single scheme for Australia will replace the current state systems. It will help enable practitioners to work anywhere in the country without red tape, while maintaining and improving patient safety and the quality of the health workforce.

New investments in Australia's health workforce under the National Health and Hospitals Network

The Government will build on the reforms it is already delivering with a \$643 million investment in new health workforce training and support measures. These will ensure our health workforce meets the needs of Australians today – particularly in areas of shortage – as well as the growing demands of the future.

These reforms build on the Government's commitment to ongoing funding of 60 per cent of the costs of training undertaken in public hospitals. This will make the Commonwealth Government the majority funder of training for future doctors, nurses and allied health professionals. The Commonwealth's new role in funding training will help ensure that training is not at risk of underfunding due to the financial pressures facing public hospitals.

More GPs to increase access to GP and primary health care in the community

The Government will invest \$339 million to increase GP training places to record levels.

While the number of medical students graduating from our universities will double over the next five years, there has not been a sufficient increase in GP training places to enable more graduating medical students to become GPs.

That is why the Government will raise the number of places available for medical graduates to train to become a GP to 1,200 per year by 2014, as shown in figure nine.

- › This investment will double the annual limit of 600 training places which was in place in 2007, with 50 per cent of all GP training delivered in regional, rural and remote Australia.
- › By 2013 this will provide around 5 million extra medical services to the community, when combined with other investments made since 2007.

Figure 9: GP training places per year, 2004–2014



The Government's investments will enable around 40 per cent of Commonwealth supported medical graduates to choose general practice as a career. Combined with recent health workforce investments, they will deliver an additional 5,500 new GPs or GPs undergoing training over the next decade.

These reforms build on the Government's commitment to taking full funding and policy responsibility for GP and primary health care. They will ensure these Commonwealth funded GP services have the workforce needed to keep Australians healthy with high quality and accessible treatment in the community.

More places each year for junior doctors to experience a career in general practice

The Government will invest \$148 million to ensure that more junior doctors can gain experience in general practice before they enter a general practice or other specialist training program.

This investment will expand the successful Prevocational General Practice Placements Program (PGPPP), more than doubling the number of places available from around 400 in 2010 to 975 places each year by 2013–14. This will provide an additional 575 students per year with the opportunity to undertake a 10 to 12 week placement in general practice.

This expansion will ensure the increased number of medical graduates coming through the system will be able to experience high quality general practice training – under the supervision of an experienced GP – during their postgraduate training period.

This will expand overall training capacity and encourage more graduating students to choose a career in general practice. For those students who do not end up becoming GPs, their personal experience becomes a vital part of improving the integration between the hospital system and GP services.

Training record numbers of specialist doctors

The Government will provide \$145 million to address workforce shortages and train more specialist doctors where the community needs them.

These investments will more than double the current number of specialist training rotations through the community and private sector from 360 to 900 by 2014, when combined with recent Government investments.

Over the next decade this will increase the capacity of the specialist training programs and deliver an equivalent of 680 specialists into the health system.

Priority will be given to providing training places in the communities where Australians need them, such as in rural and regional areas.

Traditionally, medical specialist training has been provided in public hospitals, with relatively little training occurring in the private sector. With a significant amount of health service delivery now occurring in the private sector, the Government will draw on the private sector to expand overall capacity for specialist training.

Specialties in which shortages currently exist will be targeted. These include general surgery, pathology, radiology, obstetrics and gynaecology, and dermatology. Training targets will be developed in consultation with the medical colleges and states, along with Health Workforce Australia. This will ensure the additional places are targeted to specialties for which workforce and training capacity shortages are the greatest.

Supporting and growing our rural allied health workforce

The Government will build on the steps it has taken to address workforce shortages in rural and regional Australia by investing an additional \$6 million to expand clinical training scholarships for allied health students in rural and regional areas.

By expanding this successful program, the Government will more than double the number of existing scholarships available each year from 100 to 200 each year – providing 1,000 extra scholarships for allied health students over the next decade. This will help undergraduate students in disciplines such as psychology, physiotherapy and podiatry to experience clinical practice in regions with a significant workforce shortage.

The Government is also introducing measures to help rural communities retain their allied health workers. A new \$5 million rural locum scheme for allied health professionals, will ensure these hard-working health professionals have the support to help them access education and holiday cover. The scheme will provide 100 allied health locum placements per year, supporting 1,000 allied health workers over the next decade.

Time off for continuing education, and feeling able to go on holiday without letting patients down, are essential to sustaining the rural and regional workforce. Again, this measure builds on the support the Government provides to rural doctors through locum schemes. This will be the first time allied health professionals working in rural areas can access such a scheme.

Supporting nurses to stay in the workforce

The Government recognises the importance of addressing critical shortages in the nursing workforce. This is particularly important in rural areas as nurses can often be the only health professionals available in small communities in rural and remote Australia. The Government will have more to say about this in the near future.

How the Government will implement these reforms

All the reforms and investments outlined above will commence from 1 January 2011.

The Commonwealth will increase its funding contribution to 60 per cent of the costs of training undertaken in public hospitals from 1 July 2011.

The Commonwealth Government will work with states, Health Workforce Australia and clinicians to target these reforms to critical areas of workforce shortage.

Consistent with previous COAG decisions, the Commonwealth reiterates its expectation that states provide adequate clinical training opportunities that complement the Government's new training places. This will be essential to ensuring our future doctors, nurses and allied health students get clinical training opportunities in public hospitals.

CHAPTER FOUR – AGED CARE

Better supporting older Australians by investing in aged care

The Government will invest \$739 million in aged care, including directing \$280 million to the states to support older Australians eligible for aged care in public hospitals. In total, this investment will support around 5,000 places or beds and 1,200 packages of care.

The Commonwealth Government will change the governance of aged care and become the sole funder of a nationally unified aged care system. The government will take full policy and funding responsibility for national aged care services, including a transfer to the Commonwealth of current resourcing for aged care services from the Home and Community Care (HACC) program. This will enable the development of a nationally consistent aged care system covering basic home care through to nursing homes.

The Commonwealth will invest \$32 million over the next four years so that older Australian and their families are:

- › more able to more easily access information and assessment for aged care services, through one stop shops located across the country;
- › linked to assessment services, including through the Commonwealth purchasing some more complex aged care assessment services directly from aged care assessment teams; and
- › assisted to access services in the place that best suits them.

The Government will invest more to increase the capacity of the aged care system through:

- › providing more Zero Real Interest Loans to support the development of 2,500 additional aged care places (\$143 million);
- › providing capital funding for 286 sub-acute beds or bed-equivalents in Multi-Purpose Services (\$120 million), and expanding the number of rural communities eligible to apply for Multi-Purpose Service funding, creating an additional 300 beds; and
- › working with the states to seek their commitment to release more land and accelerate planning approval processes, so that aged care homes become operational more quickly.

The Government will invest more to increase services in aged care through:

- › \$96 million over four years to improve access to primary care services for people in aged care.
- › improving the viability of community care providers (\$10 million);
- › allocating up to 2,000 time-limited flexible aged care places to states, which will provide funding to the states for Long Stay Older Patients in hospitals (providing an estimated \$280 million over the next four years to the states); and
- › 1,200 Consumer Directed Care packages, through which care recipients have a greater say in how services are provided to them.

The Government will strengthen consumer protections in aged care and toughen prudential requirements to protect residents' savings (\$25 million).

The Government will also provide the Productivity Commission with terms of reference for an inquiry into the aged care system, following consultation with the states – to set out a path for reform to ensure that the sector is equipped to deal with future challenges.

Australia's aged care system today

In 2009, there were 2.9 million people in Australia aged 65 or over, accounting for 13 per cent of the population. Around one million of these older Australians received assistance from aged and community care services.

On the whole, Australia's aged care system provides targeted, affordable and high quality care. But a number of challenges need to be addressed to ensure the needs of Australia's growing number of elderly people are met.

An ageing population

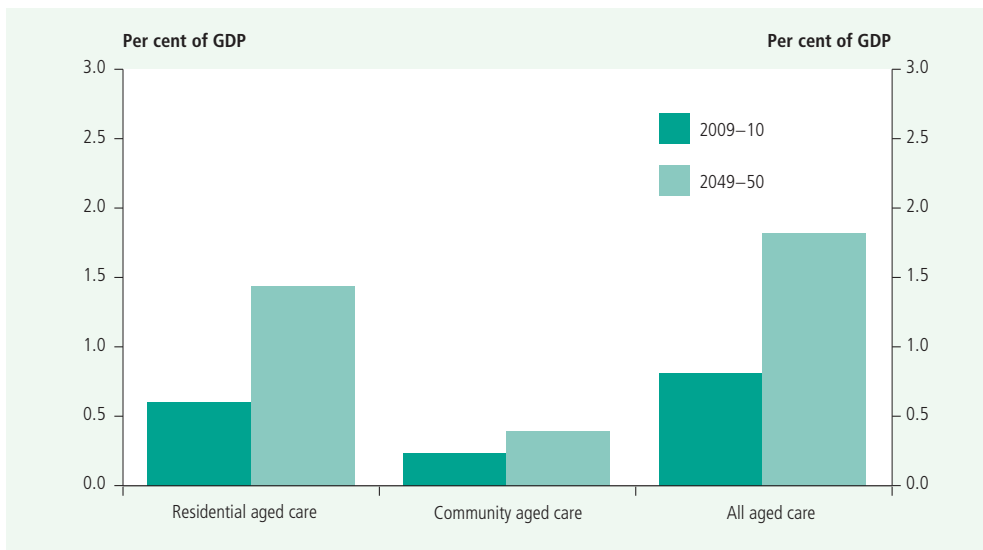
A consequence of the ageing of our population will be growing numbers of older people needing aged care services.

The 2010 Intergenerational Report forecasts the proportion of our population aged 65 or over to increase from 14 per cent in 2010 to 23 per cent by 2050. The number of people aged 85 or over is expected to more than quadruple over the next 40 years, to 1.8 million people by 2050.

The NHHRC estimated that as a result of population ageing, using the current targets for provision of aged care, the number of aged care places will need to at least double by 2030 (from 223,000 places to about 464,000 places).

This will lead to increased spending pressure on aged care. Figure ten shows spending on aged care is projected to more than double from 0.8 per cent of GDP in 2009–10 to 1.8 per cent of GDP in 2049–50.

Figure 10: Composition of Commonwealth Government aged care spending



Source: Commonwealth of Australia, Intergenerational Report 2010.

A fragmented system, leading to cost shifting and blame shifting

The aged care system is fragmented, with divided responsibilities between Commonwealth and state governments. This makes it difficult for older people and their carers to find and access the care that best suits their needs. It leads to inefficiencies and duplication in service provision.

Consequences of the split roles and responsibilities include:

- › The services provided for different programs run by different governments overlap, and have different cost structures and eligibility requirements.
- › Older Australians, their families and carers find it hard to access the services they need and often do not know what services are available. This is because different levels of government and different programs tend to offer information on their own services rather than on the aged care system as a whole.

- › Care being too closely tied to program and funding criteria and not responsive enough to people’s changing needs – with this rigidity also serving to restrict innovation.
- › Different quality assurance and complaint systems for different programs funded by different levels of government.
- › Cost shifting and blame shifting between the aged care and disability service systems relating to responsibility for younger people with disabilities in aged care services, and people with disabilities who are ageing.

Pressure on hospitals from a lack of GP and primary health care services in aged care

Too many older Australians are unnecessarily admitted to hospital when better care in the community and in aged care homes would have kept them healthy and out of hospital.

A recent study estimated that 31 per cent of transfers from aged care homes to hospitals (about 27,000 admissions each year) were potentially avoidable, including:

- › admissions due to non-urgent symptoms that would have been suitable for assessment and management in the aged care home (48 per cent of avoidable admissions); and
- › wounds for which assessment and management, including suturing, which could have been undertaken in the aged care home (23 per cent of avoidable admissions).

Aged care homes also report difficulties obtaining GP services, with nearly three quarters of aged care homes reporting difficulties obtaining GP input at least some of the time for routine tasks, such as reviewing medication charts, prescriptions or general support.

Older Australians are spending longer in hospital than necessary

Too many older Australians spend longer than they need to in acute hospital beds due to a lack of services available in the community:

- › People aged 65 or over account for around 65 per cent of hospital stays for rehabilitation and over 70 per cent of hospital stays for palliative care.
- › Over 26 per cent of patient days for admitted patients aged 85 years or over are classified as maintenance care or rehabilitation.
- › Three quarters of hospital admissions for patients aged 75 to 84 and two thirds of hospital admissions for patients aged 85 or over are for acute care, compared to 99 per cent for patients aged under 65.

In 2006, about 2,400 patients eligible and approved for aged care and no longer requiring care in hospital were waiting in a hospital bed for an aged care place to become available ('Long Stay Older Patients'), with 63 per cent waiting in hospital for more than 35 days. There were approximately:

- › 1,300 patients in regional, rural and remote hospitals; and
- › 1,100 patients in metropolitan hospitals.

Older Australians waiting in hospital for an aged care bed is an inefficient use of hospital resources and taxpayers' money. The average cost to governments of providing maintenance care to an older person in hospital is estimated to be about \$700 per day, compared to about \$220 per day in transition care and \$110 per day in residential care.

Access to residential aged care

The supply of high level residential care is not keeping up with increased demand from population ageing. The residential aged care sector, and in particular the high level care sector (nursing homes), needs to expand capacity to meet the increasing demand driven by population ageing. However, there has recently been a significant downturn in construction activity in the residential aged care sector. The value of aged care building commencements for the June quarter in 2009 was \$262 million – a decline of 29 per cent when compared to the same quarter in 2008.

In recent years the Government has also not been receiving enough suitable applications from qualified residential aged care providers to be able to allocate all available places. Without action, frail older people will face increasing difficulty in accessing residential aged care services, with implications for the hospital system.

The need for robust investigation and handling of complaints

Complaints about service provision in aged care continue to increase, from 6,818 contacts with the complaints system in 2006–07 to 12,573 contacts in 2008–09. Many complaints are characterised by increasing clinical and legal complexity.

A robust complaints scheme is central to maintaining regulatory oversight of the sector and maintaining public confidence in the aged care system. It is particularly important given the vulnerability of many older Australians in residential aged care.

The volume and complexity of complaints received poses a risk that incidents threatening resident safety may not be identified and acted upon quickly enough.

Workforce shortages

Workforce shortages compound the challenges faced by the aged care sector. The numbers of registered and enrolled nurses in residential aged care have been falling in recent years. There is a lack of a clear career path for nurse and non-nurse aged care workers. Nurse training in aged care settings tends to be constrained and haphazard because of strained budgets and limited clinical supervision. There are no clinical or graduate training placement programs in aged care.

What the Government has done so far

Since 2007, the Government has increased the provision of care for older Australians through:

- › over 6,300 additional residential care places – almost half of them in high care;
- › over 2,800 additional community care places; and
- › almost 700 additional transition care places.

Funding for aged care has increased by more than \$1.7 billion (an increase of 20 per cent) to more than \$10 billion in 2009–10.

The Government has:

- › improved access to care in regions where there was a high need for more aged care by making available \$300 million in Zero Real Interest Loans for more than 2,500 aged care places;
- › invested \$408 million over four years to increase the Conditional Adjustment Payment for eligible residential aged care providers to improve the quality, accessibility and sustainability of the aged care sector;
- › invested \$15 million over two years to increase the viability supplement paid to eligible residential aged care providers in rural and remote areas;
- › ensured that the benefit of the September 2009 pension increase was shared between residents and providers – ensuring both groups were better off. This resulted in an additional \$728 million going to care providers over four years;
- › invested strongly in a skilled aged care workforce by providing \$135 million for training for more than 21,600 aged care workers;
- › supported the delivery of care services in remote and Aboriginal and Torres Strait Islander communities by creating more than 500 permanent part-time jobs for Aboriginal and Torres Strait Islander people in rural and remote aged care services; and
- › helped ensure the safety and security of people receiving care through strengthened police checks for staff, improved reporting requirements for missing residents and improvement to the Aged Care Complaints Investigation Scheme.

Improvements for aged care through the National Health and Hospitals Network

Under the National Health and Hospitals Network, the Commonwealth will become for the first time the majority funder of all parts of the health system. The Commonwealth will be the majority funder of public hospitals and have full funding and policy responsibility for GP and primary health care services.

This will provide strong incentives for the Commonwealth to ensure that patients are provided care in the most appropriate and efficient setting possible. For example, the Commonwealth will have an incentive to improve access to aged care, so that older Australians do not remain in expensive hospital beds inappropriately. The Commonwealth will also have an incentive to ensure people in residential aged care receive appropriate clinical care, so that they are not hospitalised unnecessarily.

The National Health and Hospitals Network will support more consistent cooperation between health and aged care services at the local level. Local Hospital Networks and primary health care organisations will be required to work closely with other local health services, including local aged and community care services.

New investments in aged care under the National Health and Hospitals Network

The Government will build on the investments it has already made with a \$739 million investment in aged care (including directing \$280 million to the states to support older Australians in public hospitals who have been assessed as being eligible for aged care). This investment will be directed at key pressure points in the system today, and will help meet the growing demands of the future.

These reforms build on the Government's commitment to take majority funding responsibility for Australia's public hospitals. By improving access and quality of care in the aged care system, these reforms will help take pressure off our public hospitals.

In addition to these investments today, the Government will provide terms of reference to the Productivity Commission to undertake a major inquiry into the aged care system. These will be released at the April COAG meeting following consultation with the states. The Inquiry will set out the path for further structural reform in the aged care sector, to ensure that it is equipped to meet the challenges of tomorrow.

Improving the governance of the aged care system

Taking full funding and policy responsibility for aged care across Australia

The Commonwealth Government will become the sole funder of national aged care services across Australia. For the first time, the Government will be able to build a nationally consistent aged care system allowing older people to seamlessly move from basic help at home through to residential care as their care needs change.

This will provide a platform to deliver:

- › seamless transition of care for clients, allowing people to move from one level of care to another as their care needs change;
- › simple access to services;
- › greater integration and innovation in services; and
- › a nationally consistent system of services, support, assessment, care and regulation across the country.

This will ensure that aged care recipients and providers deal with only one level of government, improving care and strengthening outcomes. For example, care recipients whose needs increase will find it easier to access additional services. Currently, when a care recipient's needs increase they often need to leave the provider with whom they have built up a relationship and move to a new provider in a different program.

The reporting burden on providers, and especially those who currently operate services under more than one aged care program, will also be reduced. Providers will be able to diversify the services that they offer without needing to negotiate different funding agreements with different governments.

The Commonwealth will take responsibility for funding all national aged care services for older people (throughout, this refers to non-Indigenous people aged 65 or over, and Indigenous people aged 50 or over). States will be responsible for funding care services for younger people – such as younger people with disabilities – wherever they are receiving care.

The Commonwealth will work with COAG in relation to the HACC program. The Commonwealth will assume funding and program responsibility for basic community care maintenance and support services currently delivered through HACC for older people, in line with its responsibility for other national aged care programs. The Commonwealth will combine this program with its existing community care and residential care programs to create a truly national aged care system. This will include negotiations with the states around ensuring continuity of funding for existing providers during the transition period.

The states will be responsible for basic community care maintenance and support services for people under the age of 65 years, in line with their principal responsibility for delivery of other disability services under the National Disability Agreement, and will be better able to integrate these services into their broader disability support systems. The Commonwealth will continue to contribute national leadership and funding to the states for specialist disability services under the National Disability Agreement. This clarification of responsibilities will provide the Commonwealth and states with a sound platform to further develop the National Disability Strategy, particularly taking into account the recommendations of the current Productivity Commission public inquiry into Disability Care and Support.

In addition, to further strengthen and clarify responsibilities for services to these client groups, the Commonwealth will assume full funding responsibility for specialist disability services delivered under the National Disability Agreement for people aged 65 years or over.

States will assume full funding responsibility for packaged community aged care and residential aged care delivered through the Commonwealth aged care program to people under the age of 65 years (under 50 years for Indigenous people). Current arrangements for access to aged care services for younger people with disabilities will remain unchanged.

The NHHRC recommended this reform to enable:

- › more simplified and integrated assessment across all forms of aged care; and
- › more integrated provision of aged care across the spectrum from low levels of support in the community through higher levels of community care, to high level residential care.

A key reform principle will be to minimise disruption for care recipients. Care recipients will continue to receive services from their current providers while administration and funding transitions to the new arrangements. There will be no increase in the regulatory burden for providers of community aged care services.

It is expected that the current mix of community care service providers, which includes a mixture of local government, state agencies and non-government providers, will continue. Current HACC service providers will be able to continue delivering community care services to both frail older people and younger people with disabilities, or to specialise in services to particular client groups, as many do now.

The Commonwealth and states will involve service providers and other stakeholders in the reform process to ensure that the future system of community care builds on the strengths of the existing service infrastructure, the experience of the workforce and the needs of local communities.

Helping older people to move seamlessly through the aged care system

To ensure that older Australians are served as best as they can, the Government will move towards establishing arrangements that help older Australians find and access the services that suit their needs and better integrate aged care with the other parts of the health system.

These arrangements will ultimately ensure that aged care services are coordinated with hospitals and primary care services and they work with one another to provide better integrated and more efficient care.

As a step towards achieving this outcome, the Commonwealth will invest \$32 million over the next four years so that older Australian and their families can:

- › More easily access information and assessment for aged care services, through establishing one-stop-shops across the country.
- › Be linked to assessment services, including through the Commonwealth purchasing some more complex aged care assessment services directly from aged care assessment teams.
- › Be assisted to access services in the place that best suits them.

Over time, the Government will work with aged care providers to ensure that they are supported in helping older Australians and their families receive the right services as their needs change, and in working with Local Hospital Networks and primary health care organisations to ensure that the health and aged care system works seamlessly in the interests of consumers. The Commonwealth funding of all aged care services will provide a platform to promote the development of a wider variety of services and allow more innovative approaches.

Increasing the capacity of the aged care system

The Government will increase support for investment in aged care and ensure that rural and remote aged care services receive additional assistance.

The Commonwealth will invest a total of \$263 million over four years to improve access to aged care. This investment will:

- › expand the Zero Real Interest Loans program to support the construction of an additional 2,500 aged care places (at a cost of \$143 million); and
- › capital funding for 286 sub-acute beds or their equivalent in rural and remote Multi-Purpose Services (\$120 million).

The Government will also work with states and seek their commitment to release more land for aged care and to accelerate planning approval processes, so that aged care places can become operational more quickly.

More Zero Real Interest Loans

To support investment in residential aged care facilities, the Government will provide an additional \$143 million which will subsidise \$300 million in Zero Real Interest Loans to support the construction of an additional 2,500 aged care places, providing care for an estimated 3,600 people per year when fully implemented.

These loans will be specifically targeted to areas which have relatively higher numbers of older people in hospitals. The additional high level residential aged care beds constructed with these loans will free up existing acute care bed capacity in public hospitals.

This measure will also enhance the Zero Real Interest Loans program through expanding the definition of high need areas, extending the eligibility criteria and extending the repayment period for new Zero Real Interest Loans from the current 12 years to 22 years, to better match the investment profile of these developments.

Expanding Multi-Purpose Services to support rural and remote areas

The Government will provide support to expand Multi-Purpose Services through the provision of new funding for additional services and through improving the existing program guidelines to deliver additional capacity.

Multi-Purpose Services provide integrated health and aged care services, generally in hospital settings, and are an important option for the delivery of hospital and aged care services in rural and remote areas. They allow services to exist in regions that could not support stand alone hospitals or aged care homes by achieving economies of scope where economies of scale are not available.

To better support people in rural and remote areas, the Government will provide capital funding of \$120 million over the next four years for 286 sub-acute beds or bed-equivalents in Multi-Purpose Services, building on the existing 126 Multi-Purpose Services. This will support up to 5,400 people a year when fully implemented.

The Government will also alter its current guidelines to expand the number of rural communities eligible to apply for Multi-Purpose Service funding. These changes will create an additional 300 beds.

Taken together, these measures represent a substantial increase to boost the current capacity of 3,076 places in Multi-Purpose Services.

More land and faster development for residential aged care

The Commonwealth Government will work with the states and seek their commitment to release more land for aged care.

The Commonwealth will also work through COAG to accelerate planning approval processes, allowing places to become operational more quickly. For example the kind of actions that could be pursued include:

- › identifying aged care as a priority in state planning systems;
- › recognising residential aged care as class of residential development that may not require the same approval requirements; and
- › a process for determination of aged care development applications that are not finalised within 12 months.

Increasing the number of services in aged care

Improving access to GP and primary health care services in aged care

The Government will invest \$96 million over the next four years to increase financial incentives to GPs to provide more services in aged care homes and to provide flexible funding to target gaps in primary health care for older Australians, in order to provide older Australians with care in their place of residence. This will improve older Australians' access to care, and help reduce avoidable hospital admissions.

This will deliver:

- › a 50 per cent increase in the payment to GPs who provide at least 60 attendances to residents of aged care homes from \$1,000 to \$1,500 a year; and
- › more than double the payment to GPs who provide at least 140 attendances to residents of aged care homes from \$1,500 to \$3,500 a year.

This is expected to support around 105,000 additional GP services being provided to older Australians in aged care homes in the four years to 2013–14. Up to 1,200 additional providers are expected to be receiving incentive payments by 2013–14 for providing services to patients in residential aged care facilities.

The Government will also provide funding for primary health care organisations from 2012-13 to increase access for older Australians to GP and primary health care. Primary health care organisations will administer a flexible funding pool to target gaps in primary health care services for aged care recipients. This is expected to result in an additional 190,000 primary health care services in the two years to 2013–14.

Improving the viability of community aged care providers

The Government will improve support for community aged care through investing \$10 million over four years to continue and increase the viability supplement for community aged care providers. This will mean a real increase for the first time in the viability supplement for rural and remote community care providers. This increase will provide a much needed boost to community aged care services in regional, rural and remote areas where earnings are much lower than in major cities.

Financial assistance for Long Stay Older Patients

The Government will also provide an estimated \$280 million in assistance to states over four years to meet the cost of Long Stay Older Patients in public hospitals.

'Long Stay Older Patients' are older Australians in public hospitals who have been assessed as needing aged care but who cannot be discharged because they cannot access appropriate aged care services. The Government will allocate 2,000 time-limited flexible aged care places to states under the *Aged Care Act's* Innovative Pool arrangements. States will receive funding for these places equivalent to the average aged care subsidy for people entering residential care from hospital.

Enabling care recipients to have more say in the care they receive

The Government will increase funding for opportunities for care recipients to be more active in shaping their care through 1,200 innovative Consumer Directed Care packages in Commonwealth funded community care programs. Up to 500 community care and 200 respite packages will be released in 2010–11 for this purpose, followed by another 500 community care packages in 2011–12.

Consumer Directed Care has been shown to improve care recipients' quality of life, independence and satisfaction.

Consumer direction allows care recipients and their carers to have greater control over their own lives by allowing them – to the extent that they are capable and wish to do so – to make choices about the types of care services they access and the delivery of those services. This includes choices about who will deliver the services, and when they are delivered. For example, care recipients are able to have a greater say as to which formal carer is employed to deliver their assistance and as to the times when that assistance is provided.

Improving consumer focus and protection in aged care

The Government will invest a total of \$25 million to improve the consumer focus of aged care and reduce the complexity of the current arrangements by:

- › better equipping the Aged Care Complaints Investigation Scheme in 2010–11 to improve complaint handling and provide access to mediation and conciliation; and
- › strengthening the regulation of aged care providers who hold accommodation bonds, with effect from 1 July 2011.

Strengthening investigation and handling of aged care complaints

The Government will increase funding for the Aged Care Complaints Investigation Scheme. The Government will also provide older people and their families access to mediation and conciliation as an additional means of addressing concerns. Funding will be provided for additional staff and improved procedures for managing cases. In addition, the case loads of officers will be reduced to ensure investigations can be handled more quickly and thoroughly.

Protecting aged care residents' savings

To better protect aged care residents who have paid accommodation bonds from their life savings, the Government will introduce more stringent rules for how bond money can be invested and improve reporting requirements.

Approved providers of residential aged care hold substantial accommodation bonds paid by their residents:

- › As at 30 June 2009, aged care providers held over 58,000 bonds with a total value of around \$9.0 billion.
- › This has more than doubled from \$4.3 billion in the four years since 30 June 2005.
- › The average bond holding is \$9.3 million per provider.
- › The largest 10 bond holders hold around 22 per cent of all bond monies.

Without regulatory change there is a risk that approved providers may use accommodation bonds for other than the intended purposes of infrastructure improvement and debt reduction. The Government will therefore introduce more stringent rule for how bond money can be invested and improved reporting requirement. The Government will consult with consumers and the industry and will work with relevant bodies to strengthen risk based prudential arrangements, with a view to putting new arrangements in place from 1 July 2011.

How the Government will implement this reform

Improving the governance of the aged care system

- › The Government will work with the states and other stakeholders to manage the orderly transition of the management of Home and Community Care (HACC) services for older people from the states to the Commonwealth. The Commonwealth will assume responsibility for the management of aged care HACC services from 1 July 2012.
- › The Government will also work with the states to develop the required funding arrangements, which will come into effect from 1 July 2011, at the same time as the other financial changes in the National Health and Hospitals Network.
- › The Government will establish the network of one stop shops by 1 July 2011, with the new assessment and referral arrangements commencing on 1 July 2012.

Increasing the capacity of aged care

- › The Government will allocate \$300 million in Zero Real Interest Loans and associated places in two tranches through the 2010–11 and 2011–12 Aged Care Approvals Rounds.
- › Capital support for sub-acute care beds in Multi-purpose Services will commence in 2010–11.
- › The Government will work with the states from 2010–11 to improve planning approvals for aged care.

Increasing the number of aged care services

- › The Government will provide increased incentive payments under the Aged Care Access Initiative (ACAI) for GPs to provide services to residents of aged care homes from 1 July 2010.
- › New flexible local funding through primary health care organisations for targeted primary health care services will commence from 1 July 2012.
- › From 1 July 2010, the Government will provide a real increase for the first time in the viability supplement for rural and remote community care providers.
- › The Commonwealth will work with the states and territories to identify Long Stay Older Patients eligible for Commonwealth assistance, with payments commencing on 1 July 2011.
- › The Government will fund up to 1,200 Consumer Directed Care packages from 1 July 2010 to give care recipients a more active role in shaping the care they receive.

Improving consumer protection in aged care

- › The Government will better equip the Complaints Investigation Scheme to ensure investigations are handled quickly and thoroughly and to provide older people and their families with access to mediation and conciliation from 1 July 2011.
- › The Government will strengthen risk based prudential arrangements in 2010–11.

CHAPTER FIVE – BUILDING THE NATIONAL HEALTH AND HOSPITALS NETWORK

The Government's reforms and investments to establish the National Health and Hospitals Network will deliver an effective, efficient health system that governments and taxpayers can be confident will be sustainable into the future.

The reforms, which represent the most significant changes to Australia's health and hospital system since the introduction of Medicare, rests on a simple premise – a National Health and Hospitals Network with which is funded nationally, and run locally.

Funded nationally – building the foundations for investment

Providing a secure funding base for health and hospitals into the future

The Commonwealth Government will take majority financial responsibility for the health and hospital system – paying 60 per cent of the efficient price of all public hospital services provided to public patients and taking full financial responsibility for GP and primary health care, and aged care. This will provide a secure funding base for public hospitals into the future, responding to the risk that states will not have the financial capacity to meet rapidly increasing health spending obligations in the longer term. On current projections spending on health and hospitals would consume the entire revenue raised by state governments in 2045–46.

Whereas the Commonwealth now only pays around 33 cents in each dollar of future growth in health care costs, under the new arrangements the Commonwealth will permanently pay 60 cents in each dollar of growth in health costs.

As part of these new funding arrangements, around one-third of total GST revenue will be set aside in the National Health and Hospitals Network Fund to directly fund health spending. This will provide an increasing benefit that will accrue to states over time, starting with an estimated \$15.6 billion in additional growth costs from 2014–15 to 2019–20.

The benefits to states will grow significantly beyond this period, as the gap widens year on year between the growth of general consumption (the GST revenue base) and burgeoning health costs.

Hospital costs have been growing at close to 10 per cent per annum in the five years to 2007–08, and are expected to continue to substantially outpace growth in GST revenue over the medium term.

The Government's estimate of these benefits to states under the National Health and Hospitals Network is based on conservative assumptions. The Government's projections assume hospital costs will grow at 8 per cent per annum into the future – compared to growth in GST revenue of 6 per cent per annum.

In addition, by taking on majority funding responsibility for health and hospitals the Commonwealth is also improving the long run productivity of the Australian economy. The level of government with the most stable and efficient means of raising revenue will now be the majority funder of the fastest growing area of public expenditure.

New, higher national standards across the National Health and Hospitals Network

The Commonwealth Government will use its position as the majority funder of health and hospital services in Australia to set new, higher national standards for health care. These standards will apply right across Australia, underpinning a nationally unified health system.

The increased efficiency and transparency delivered by the Government's reforms provide the base for the investments needed to achieve the national standards that will be a cornerstone of the National Health and Hospitals Network.

For instance, the Government's structural reforms provide the foundation for the \$1.2 billion of new investments in public hospital services outlined in this document to reach new, higher national standards for access to services, including:

- › a reduction in emergency department waiting times to a maximum of four hours; and
- › a target of 95 per cent of elective surgeries within clinically recommended times, backed by a guarantee of free rapid treatment to be rapidly provided in a public or private hospital if patients wait longer than is recommended.

These new national standards will be used over time to drive improved performance right across hospital and GP and primary health care services. Over time, the Commonwealth will seek to strengthen the link between performance and funding, to reward achievement of these standards.

Transparent reporting of performance against new, higher national standards

The Government will introduce clear and transparent performance reporting against high national standards and other performance indicators to provide Australians with more information than ever before about the performance of their health and hospital services. For the first time, this performance information will be both nationally consistent and locally relevant.

Hospital Performance Reports and Healthy Communities Reports will help Australians make more informed choices about their health services. They will clearly and quickly identify areas of high performance, and support the spread of effective and innovative practices across the country. They will help ensure the standard of care patients receive continues to improve. Transparent reporting will also allow poor performance to be quickly and easily identified, so that interventions can be made before problems become entrenched.

The combination of funding following services actually provided and new national transparency measures will mean communities have more information than ever before on how well hospitals are performing, how their hospitals are funded, and what services are provided to them. Equivalent information will also be provided on primary health care performance.

The Government will work closely with health and hospital stakeholders, including clinicians, states, local governments and patients, to develop the structure of these performance reports, and to identify what data is already available and what will need to be developed over time.

Supporting the right care in the right place – and reducing cost shifting

Currently, Australia's rates of hospitalisation are much higher than in many comparable countries. This is an indication that resources are not allocated in the most effective way across our health system. Patients are ending up in hospital – and taxpayers and governments are funding highly expensive hospital services – when better treatment in the community could keep them healthy, out of hospital, and in many cases in the workforce.

The Commonwealth Government becoming majority funder of public hospitals, and taking full responsibility for primary and aged care, will lead to resources being allocated more effectively. This clarification of roles and responsibilities creates a powerful structural incentive for the Commonwealth to keep people healthy and out of hospital, as the Commonwealth will now foot the majority of the hospital bill.

That is why the Commonwealth is taking the steps outlined in this document to improve care in the community and help keep patients healthy and out of hospital. Increasing access to aged care services and providing coordinated care for patients with diabetes – among the Government’s other reforms and investments – will ensure patients receive care in the community that responds to their individual circumstances. They will improve patients’ quality of life, take the pressure off our public hospitals, and improve the financial sustainability of our health and hospital system.

Run locally – local management, community engagement and better regional coordination

Increasing the efficiency of health and hospital services by paying Local Hospital Networks directly for the services they provide

The Government’s reforms to establish the National Health and Hospitals Network will remove much of the duplication and inefficiency in our health system today. These reforms will give the Commonwealth and the community confidence that scarce health funds are being used as efficiently and effectively as possible. They will deliver improvements in vital services for Australians as well as driving real economic reform in a sector which comprises almost ten per cent of the Australian economy.

Paying Local Hospital Networks directly for the services which they provide is an essential element of the new funding arrangements under the National Health and Hospitals Network.

Critically, this model will drive greater transparency about state and Commonwealth funding. Current funding models are opaque to the Commonwealth and the performance and accountability of states vary widely. The Commonwealth and the public have little visibility of how funding is being used to deliver services.

The Commonwealth is prepared to shoulder the burden of 60 per cent of future hospital growth over the coming decades, but only if there is greater levels of transparency about where taxpayers’ funding is being spent in local communities.

Paying Local Hospitals Networks directly will achieve this for the first time. The Commonwealth’s funding will be directed to the bodies responsible for delivering services, and these bodies will be paid on the basis of the services they actually deliver. Without paying Local Hospital networks directly, the Commonwealth will lose significant leverage to insist on system wide reform, including accountability at the local level for attainment of new, higher national standards.

For states, direct payment will ensure that there is much greater certainty around public hospital funding than under the current National Healthcare Agreement. The Commonwealth's contribution of 60 per cent of the efficient price will flow automatically as services are delivered by Local Hospital Networks. As outlined in *A National Health and Hospitals Network for Australia's Future*, the service levels and mix of services Local Hospital Networks deliver will be determined by agreements between states and Local Hospital Networks.

In addition, the national efficient price for hospital services will be set by a national independent umpire. This will mean that for the first time states won't be left footing the bill because of inadequate indexation.

While paying Local Hospital Networks directly is integral to the National Health and Hospitals Network, some payments are still best made at the state level to allow for system-wide resource allocation. This is particularly true for research, training and block grants, including for small rural and regional hospitals.

Local Hospital Networks to drive performance and accountability

As outlined in *A National Health and Hospitals Network for Australia's Future*, Local Hospital Networks will be small groups of hospitals with a geographic or functional connection, but large enough to operate efficiently and provide a range of hospital services. They will coordinate and deliver a comprehensive set of services within a local area.

States will remain responsible for system-wide service planning and capital planning. They will make decisions which span multiple Networks, such as where to build new hospitals.

Devolving decision making to Local Hospital Networks will give communities and clinicians a greater say in how their hospitals are run. Paying Local Hospital Networks directly creates a strong incentive for local managers and clinicians to increase service levels and reduce costs. These arrangements will provide more flexibility for local managers and local clinicians to drive innovation, efficiency and improvements for patients.

Local Hospital Networks will deliver improved clinical engagement, which will be an important driver of innovation and productivity. The corporate governance of the Local Hospital Networks will include clinicians on the Governing Council. Local Hospital Networks will work with local clinicians to incorporate their views, especially on quality and safety, into the day to day operation of hospitals.

Primary health care organisations to improve responsiveness to local patients' needs

Primary health care organisations will improve the delivery of GP and primary health care services at the local level – for example, through facilitating access to allied health services for patients with chronic conditions. By coordinating these kinds of services, primary health care organisations will ensure local primary care is better integrated and more responsive to the needs and priorities of patients and communities.

By identifying and helping to fill gaps in service delivery, primary health care organisations will be able to complement services provided by GPs. For example, they will be able to ensure that when a patient leaves hospital, they have a usual GP who they can go to for follow up care, and put them in touch with one if they don't.

Primary health care organisations will work with local GPs and Local Hospital Networks to improve patient care and the quality and safety of health services. Primary health care organisations will also work closely with practitioners and services in the primary health care, hospital, aged care and Indigenous health sectors to support greater collaboration between service providers.

Support better coordination at the local level

Primary health care organisations will work with Local Hospital Networks to improve patient care and the quality of health and hospital services. Together they will ensure that GP and primary health care and hospital care are better integrated, so patients smoothly transition in and out of hospital and continue to receive all the care they need. This could include working with relevant providers to help patients manage their recovery and stay healthy as they are discharged from hospital.

Primary health care organisations and Local Hospital Networks will also work together to identify and address particular local needs. For example, the Local Hospital Network may identify a growing trend of diabetics admitted with foot complications. The primary health care organisation would work with local GPs and podiatrists to ensure these problems are picked up more quickly and the right skills are available.

The Government will ensure the structural foundations for improved cooperation are in place, for instance through requiring some common board membership across primary health care organisations and Local Hospital Networks.

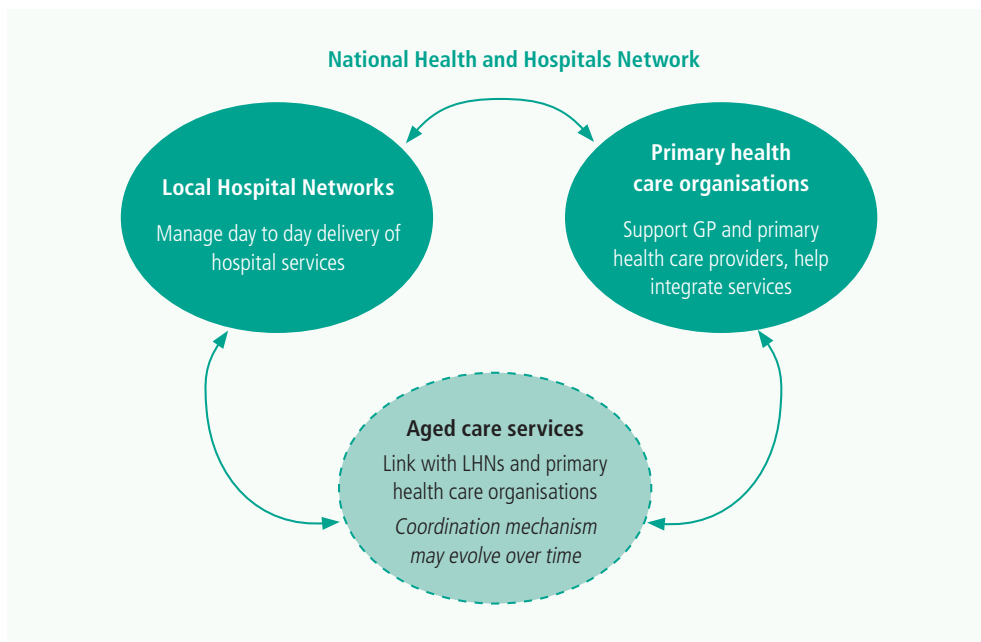
In addition, to ensure that older Australians are served as best as they can, the Government will move towards establishing arrangements that better integrate aged care with the other parts of the health system. This will help older Australians find and access the services that suit their needs.

Over time, the Government will work with the full spectrum of aged care providers – including community and respite care – to ensure that they are supported in:

- › Helping older Australians and their families receive different types of care services as their needs change – for example, through more intensive or specialised community care packages (including for dementia), respite care and residential aged care.
- › Working with Local Hospital Networks to identify appropriate care options that best suit the needs of older Australians and avoid unnecessary hospital stays, including through sub-acute and step-down care.
- › Working with primary health care organisations to improve access to and quality of GP and primary health care services provided to older Australians in a local community, irrespective of where they live.

These arrangements will ultimately ensure that aged care is coordinated with hospitals and GP and primary health care services, as shown in figure eleven. They will provide the foundation for a community of services which work with one another to provide better integrated, and more efficient care across the entire health system.

Figure 11: An integrated National Health and Hospitals Network across hospital, aged care and GP and primary health care services



Reducing blame shifting and cost shifting

The establishment of a National Health and Hospitals Network that is funded nationally and run locally will fundamentally reduce blame shifting on health and hospitals. There are three fundamental reasons why the Government's reform plan will achieve this.

1. For the first time, the Commonwealth's share of public hospital funding will become a fixed, majority share of public hospital costs

Currently, the states blame the Commonwealth for the pressures facing public hospitals because its share of public hospital funding does not keep up with growth in health costs and demand.

Under the National Health and Hospitals Network, the Commonwealth's share of public hospital funding will permanently be fixed at 60 per cent of the national efficient price of every public hospital service provided to public patients. The Commonwealth will also fund 60 per cent of the cost of training and research, 60 per cent of the cost of capital investment, and 100 per cent of the national efficient price of 'primary health care equivalent' outpatient services provided to public patients.

A new, independent hospital pricing umpire – at arm’s length from all levels of Government – will determine the efficient price of hospital services. The independent umpire will determine rate of growth in health costs, and the efficient price will be set on this basis. The umpire’s ruling will be final – and the Commonwealth will pay its fixed 60 per cent share of every hospital service that Local Hospital Networks and states agree to provide. If states need to provide more elective surgery procedures to meet community expectations, or need to provide more intensive care beds to deal with the impact of swine flu, and they are willing to fund their share, Commonwealth funding will automatically flow.

This will end the five yearly cycle of Commonwealth and state governments haggling and finger pointing over hospital funding (including indexation rates) each time health care agreements are renegotiated. It will also end the arrangements whereby the proportion of the Commonwealth’s contribution to public hospitals bears no relationship to health service demand or increasing cost.

The Commonwealth will have an ongoing role as the majority funder of public hospitals – meaning no more disputes about whether or not the Commonwealth’s share is going up or down into the future.

2. For the first time, incentives for cost shifting will be dramatically reduced – and the Commonwealth will invest properly in all parts of the health system

Currently, the states and Commonwealth shift costs onto one another, as no one level of Government is responsible for the dominant share of funding in key parts of the health system – public hospitals and GP and primary health care.

Under the National Health and Hospitals Network, the Commonwealth will become the majority funder of public hospital services, and also take full funding and policy responsibility for GP and primary health care and aged care.

This means the Commonwealth will have a strong incentive not to cost shift into the hospital system. The Commonwealth will ensure patients have appropriate access to GP and primary health care services in the community, because it will be footing the bill for expensive acute care services in public hospitals if it doesn’t.

Through the measures outlined in this document, the Government is investing heavily in primary health care which will help take the pressure off hospitals. The Government will invest \$436 million in transforming the way Australians with long term illness are treated, and \$339 million to double GP training places. The Government is also establishing independent primary health care organisations to provide better services and drive integration across GP and primary health care services.

3. For the first time, Australia's health system will be subject to high, nationally consistent standards, with performance transparent to the public

Historically, the Commonwealth and the states have blamed each other for poor service delivery and performance.

Under the National Health and Hospitals Network, the Commonwealth will set strong national standards – and it will resource states to deliver them.

For example, this document outlines investments of \$1.2 billion to improve waiting times for emergency department treatment and elective surgery, through which:

- › anyone presenting to a public hospital emergency department will be admitted to hospital, referred for treatment, or discharged within four hours, where it is clinically appropriate to do so;
- › free treatment in public or private hospitals will be rapidly provided if patients wait longer than the clinically recommended time for elective surgery; and
- › 95 per cent of patients waiting for surgery should be treated within the clinically recommended time by 2014, up from the current level of 84 per cent.

Strong national standards will be a cornerstone of the National Health and Hospitals Network. By becoming the majority funder of the system, the Commonwealth will have more incentives than ever before to make sure these standards are achieved.

Next Steps

The Government will continue to make further investments in the National Health and Hospitals Network, in both the priority areas discussed in this document, and in additional important areas such as mental health, dental care and preventive health.

In mental health, while some progress has been made in recent years in providing more services to people with common conditions such as depression and anxiety, the system is not currently meeting the needs of certain groups of people with mental illness. In particular, young people with or at risk of mental illness are not accessing the timely care they need.

In dental health, many Australians experience poor access to dental care – often because there are not enough dentists and dental professionals. Current estimates project there will be a shortfall of 2.3 million dental services in 2020. People who are socially and economically disadvantaged are much more likely to have poor dental health. The Government is committed to expanding access to dental care in Australia, for example through the establishment of the Medicare Teen Dental Plan.

The Government recognises there is much more to be done to improve access to mental health services and dental care.

Obesity, tobacco and alcohol misuse are the key common risk factors for a range of chronic diseases, including diabetes, cancer and cardiovascular disease. Since 2007 the Commonwealth Government has made unprecedented investments in prevention, committing \$872 million through COAG for preventive health programs to be rolled out in schools, workplaces and communities to help individuals modify their lifestyles to reduce the risk of chronic diseases. Nonetheless, the Government recognises there is scope for targeted further action to build on these important measures.

In addition, **e-Health** reforms will work to provide additional foundations to support improvements to the quality and efficiency of care across the National Health and Hospitals Network. The Government will be making further announcements on these reforms over the coming weeks and months.

Taking these reforms to the states

The measures outlined in this document, together with the structural reforms outlined in *A National Health and Hospitals Network for Australia's Future* will be discussed with the states at the COAG meeting on April 19.

The additional investments outlined in this document make the Government's reform proposals an even better deal for the Australian community in every state and territory. On this basis, it is an even better deal for each state and territory government.

The Commonwealth is only willing to make these additional investments on the basis of structural reform of the health and hospital system – a national system that is funded nationally and run locally. As such, investments in each state are largely contingent on implementation of reform in each state to establish a National Health and Hospitals Network. As the Government has made clear in *A National Health and Hospitals Network for Australia's Future*, it reserves the right to seek a mandate from the Australian people to implement its National Health Reform Plan.

The Government looks forward to reaching agreement on these reforms at COAG, and to getting on with the job of building the National Health and Hospitals Network.

APPENDIX A

Table A1: Investments included in *A National Health and Hospitals Network: Further Investments in Australia's Health* (2010–11 to 2013–14)

Measure	\$ million
Hospitals	1,150
Four hour National Access Target for emergency departments	500
Improving access to elective surgery	650
GP and primary health care	436
Coordinated care for patients with diabetes	436
Workforce	644
More GP training places from 2011	339
More places for each year for junior doctors to experience a career in general practice	148
Training record numbers of specialist doctors	145
Expanding clinical training scholarships for allied health students	6
Rural locum scheme for allied health professionals	5
Aged Care	739
Reform of Roles and Responsibilities – HACC	34
Aged care one stop shops	32
More Zero Real Interest Loans	143
Expanding Multi-Purpose Services	120
Improving access to GP and primary health care services in aged care	96
Improving the viability of community care providers	10
Financial assistance for Long Stay Older Patients	280*
Strengthening investigation and handling of aged care complaints	3
Protecting aged care residents' savings	22
Total	2,968

* Funded under the Aged Care Act 1997's Innovative Pool arrangements. Numbers may not sum due to rounding.

Table A2: Projected benefits to the states from A National Health and Hospitals Network

	Total new investments (\$m)*		Top up to reflect Commonwealth growth responsibilities under NHHN (\$m)
	2010–11 to 2013–14	2014–15 to 2019–20	
NSW	964		4,893
Vic	736		3,818
Qld	599		3,361
WA	304		1,677
SA	219		1,109
Tas	68		340
ACT	48		248
NT	31		167
Total	2,968		15,615

* Some funding is provided to states and some funding is provided for services in those states. All funding is based on population share. Numbers may not sum due to rounding.

Table A3: GST dedicated to health and hospitals and benefits to the states

\$ billion	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	Total
Total GST revenue	57.9	60.9	64.2	67.6	70.9	74.5	395.9
Additional Commonwealth funding responsibilities under NHHN	19.5	21.2	23.1	25.1	27.2	29.6	145.6
GST allocated to NHHN Fund	19.0	20.0	21.1	22.2	23.3	24.4	129.9
Commonwealth top up payment for NHHN Fund	0.5	1.2	2.0	2.9	3.9	5.1	15.6

GST payments current as at 2009-10 MYEFO. Additional Commonwealth health expenditure is based on Commonwealth Treasury projections. Numbers may not sum due to rounding.

