

Robyn Williams: Associate Professor Sabina Knight is a camp-drafting girl from Wee Waa. She's been a remote area nurse and educator, and keeps her hand in still doing RAN locums whenever she can. Her open-house policy in Alice Springs typifies her nature, and the warmth of the welcome one gets in central Australia. She's been president of CRANA, chair of the NRHA, and mother to Brandon. Will you please welcome Sabina Knight, to talk about the National Health and Hospital Reforms Commission's agenda for change?

## The National Health and Hospital Reform Commission's agenda for change

**Sabina Knight**<sup>1</sup>

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Thank you very much, Robyn, and good morning to everyone, and it's great to see you all here. As a remote health conference junkie, I admire the people who can get up, after a great networking evening, and with some enthusiasm, attend the morning after the night before.

May I acknowledge the traditional owners of the land that we meet on? I'd like thank you for this invitation. I think Australia's health system is a little like me; it was designed and built in the last century, not particularly agile, and whilst I'd like to think that I cope with change and anticipate change and, in fact, enjoy change, like most human beings, or the human condition, I'm a little uncomfortable with change.

So over the last year, we've been listening, reading, researching, talking to lots of people, many of you, and particular listening to the community who are just calling for change. And as we heard yesterday, there's a real readiness for change that makes this an historic and important moment, and an opportunity to get it right.

The Prime Minister established our commission to develop a long-term health reform plan for the future of health care in Australia. The themes and policy directions we're putting forward are based on the realities of today, but are designed to serve the health needs of the nation in five, 10 and 20 years' time, into the future. To quote the Prime Minister, "We're getting ahead of the curve."

Our brief was broad and our horizon is long so, by necessity, our interim report is comprehensive and covers many issues. It's not possible today to go over those 116 reform directions we presented, but I'd like to focus on some of our key messages. We've organised our reform directions under four themes, and I'll outline those for you now, and I'll give some examples of what falls under those themes.

The first of our four themes is taking responsibility, and this is about individual and collective action to build health and wellbeing; it's our call for action. And this theme emphasises that health isn't just about health care. Health is impacted by many factors; the social determinants, the environment in which we live and work, our social circumstances, our own biology and genetics and, importantly, our own behaviours and lifestyle. So if we're serious about our own health and the health of our children and future generations, we need to take some personal responsibility and collective action, and that starts with us. As parents and families and communities and health professionals, business and governments, health is everybody's business.

The second theme is in connecting care. This is about achieving comprehensive care for people over their lifetime. Connecting care is the need to complete and rebalance the chain or continual of health care and aged care services. We want to bring a greater emphasis on prevention and primary health care, help families create a healthy start to the life of their children, and reshape and refocus hospital roles, fill in the missing link of sub-acute care, and those services to assist recovery and rehabilitation, and offer greater

choice in control for people receiving aged care. Connecting care is about the gluing together of the health system for an individual throughout a particular sickness episode, through their care over a long-term chronic condition, through meeting the needs of people, in fact, over their lifetime.

Our third theme is facing inequities—and you spoke so eloquently about this, Monique—thank you. We have to recognise—and this is nothing new to this forum; this is why we exist—the National Rural Health Alliance. We need to recognise and tackle the causes and the impacts of health inequities, and in this we focus on indigenous health, remote and rural health, mental health and dental health. I recognise the last, for those outside Australia, may seem odd, but it will become clear soon. This is about having a fair health system where we make our universal entitlement real, through targeted approaches, to improve people's access to care.

Our fourth theme is about driving quality performance, and this involves making the best use of people resources, and the evolving knowledge in health. Here we cover the tough questions around governance, financing and funding, our health workforce, safety and quality, research innovation and continuous learning. So our task is really about re-engineering the architecture of Australia's health care system, or systems, which are very complex, to better place us to be able to deal with the emerging, and needs into the future.

So now I'll return to these themes and talk through some strategies and reform directions under each.

So taking responsibility: Healthy Australia goals. Under this first theme, we're proposing that, as a nation, we develop a set of shared goals. These rolling 10-year goals, the Healthy Australia 2020 goals, should be developed with broader community input and consultation. Local communities, work places, health organisations, professionals and governments, could each take some action of these goals, and there would be public reporting; regular reporting by government, on our progress, so that we stay on track.

And this leads us to our next proposal, for an independent national health promotion and prevention agency. This agency would be responsible for the national leadership in the Healthy 2020 goals; it would build an evidence base in capacity and infrastructure necessary to make prevention the platform for healthy communities right across Australia.

Our third proposal is around how we help people to take greater responsibility for their health, and I know this is a topic that interests you enormously; it's often the subject of great discussion. We know a third of the disease burden in Australia can be attributed to risk factors, for which can be reduced or prevented by personal behaviour. So if we're serious about health, and the health of our nation, and indeed, the health of our children and future generations, we have to be serious about taking greater responsibility. But it's important to realise and recognise that health choices are not easy for some, because of where they live or their social circumstances. An important building block for taking greater responsibility is, of course, your education and your health literacy; it's your level of knowledge about human health, and your understanding of personal health risks of what action can be taken.

We've proposed that health literacy be included as a core element in the national curriculum for schools, and that it be tested in the national basic skills assessment. We want a signal that this is very, very important.

I now turn to our second theme: connecting care, and this is where we focus on health services, and putting people and families at the centre; quite a shift. The health system can be reviewed as a chain of services, from prevention, primary health care, to hospitals, rehab, through to aged care—hopefully not all in that logical order in one day. And while hospitals are often the focus of public attention—the canary, perhaps, the pressure point of the whole system—we believe that the solutions for hospitals are, in the large part, strengthening other elements of the health system.

We need to complete and connect the whole service delivery continuum to enable people to get the right care, in the right settings, at the right time; not just from time to time, but over time, to meet their different needs throughout different life stages, and for this to occur, we need strong national leadership on the fundamental platform of health care; primary health care. A major reform direction is strengthening and integrating primary health care services in Australia, bringing together what we've understood as primary care, community health, into a new reformed primary health care.

It's internationally acknowledged that a good platform of primary health care is fundamental to the health of the community. Countries with well-developed primary health care services, community based care, have very strong evidence that their health systems are more efficient, accessible, and have better outcomes.

We've proposed that the commonwealth should assume responsibility for primary health care funding and policy. This would bring clear leadership, focus and accountability into what we know is fractured; this very fractured part of the whole system.

As part of this new role, we believe the commonwealth would encourage and actively foster the widespread development of comprehensive primary health care centres, and comprehensive primary health care services.

Our third key reform relates to the importance of having health care provided with continuity over time, which is particularly important for young families, and with people with chronic and complex conditions. The current system is focused on episodic care, from time to time, rather than care over time, and that's served us well in the past.

For young families and people with chronic and complex conditions, including with disability and with long-term mental illness, to have the option of enrolling with a single primary health care service of their choice is to have a primary health care home. Grant funding could be tied to the levels of enrolment, which would provide each practice, or service, the support for multi-disciplinary clinical teams, primary health care support and care co-ordination, signalling a modernisation of Medicare, and this would complement the existing fee for service payments.

To create truly connected care, we strongly urge that a personal controlled, electronic personal health record be made a reality. I sort of wait for the stamping of feet. How long has this been called for? We just can't believe that, with all the modern wonders of information and communication technology, that the record is still not available.

The Commission believes that an electronic health record for each Australian is one of the most important systemic opportunities to improve continuity, safety, reduce waste and errors, and promote best care. An electronic health record, which can be accessed, but with the person's agreement, by health professions across settings, is arguably the single most important enabler of a truly person-centred care.

Investing in a healthy start to our children's lives is one of the most powerful investments we can make in health care. From before conception, through the early years of life, there are critical windows of health potential that can be realised or lost. Our strategy is to link our focus on health promotion, strengthened primary health care, integrated with health and family services.

The option is to enrol with a primary health care centre or service, and provide an opportunity to partner with parents, to support and promote the health of young children, as they grow and develop, and our report presents a range of opportunities, including universal home visits, right through into school nurses, targeted special care for families at risk, and there's a lot more there.

I now move on to the topic that often engages the public opinion: hospitals. Waiting lists, overcrowding, safety concerns—as I said, the hospital is the canary of the current health system. Looking to the future,

the solution for pressure on the hospitals, we believe, largely lay outside. Strengthening primary health care, developing stronger community, and community-based care, filling the missing link of sub-acute and rehab services, and providing greater choices in aged care, will all help us reduce the unnecessary and avoidable demand currently placed on hospitals.

There needs to be a reshaping of hospital roles. Future planning should encourage a greater delineation of their roles, including separation of planned and emergency treatment, to make hospitals more productive and efficient, and hospital funding should reflect these roles on activity.

We support the greater use of activity-based funding for public and private hospitals, using efficient case-mix-based payments, including the cost of capital. Furthermore, to address the issue of overcrowding of emergency departments, we believe that grant funding, in addition to activity-based funding, should be provided to hospitals with major emergency departments.

With these measures, we believe we should be able to guarantee timely access of services supported by public funding, and these guarantees will be reinforced by measuring performance.

We're proposing the development and adoption of national access guarantees for planned procedures, and national access targets for emergency care. A couple of examples: we'd like national access targets for people requiring acute mental health interventions, measured in hours; national access guarantees for patients requiring critical coronary artery surgery or cancer treatment, measured in weeks or days; and a national access guarantee for patients requiring other planned surgery, measured in months. These actual measures aren't defined, but they should be developed, incorporating clinical, economic and community perspectives, perhaps through vehicles such as citizen juries. This is, after all, about how we use our finite bucket of money, so it needs to be a public, open and transparent discussion.

There's more about hospitals in our report, of course, but this now brings us to the missing link in the service chain: sub-acute services—and I wondered if this might not be that Rumsfeld moment that was mentioned yesterday: we don't know what we don't know; if we haven't got it, we haven't experienced it. And by sub-acute services, we mean rehab, geriatric evaluation, management in transition care, step-up and step-down programs; in other words, care that helps recovery, and restores people to independent living, often prevents avoidable admissions to hospital.

Many parts of Australia have very limited or poorly-developed sub-acute services, and in fact some have none at all. We present a range of reforms to fill this missing link in the care continuum, and we want investment in sub-acute services infrastructure to be one of the priorities for the health and hospital infrastructure fund. And whilst some people refer to sub-acute services as the invisible service, this can't be said for aged care. There's no doubt that there's a huge growth in demand for aged care services in Australia; with the baby boomers, and the generations advancing in years, we will see much higher consumer expectation.

In the next 20 years, in the horizon of our remit, the number of people aged 70 or over will double; the number of people aged 85 and over will triple. I guess we are subject to our own success. At the same time, smaller families, and a greater workforce participation, will mean less family carer support will be available. Aged care services need to be structured in ways that are more responsive to the needs of older people and their families, and we need to expand choice, in both care and accommodation in aged care. At the same time, we need to ensure that they're getting the best from public funding, ensuring we are protecting those who are most in need, and of course, we need a viable and responsive aged care industry to do this.

To achieve these three options, the Commission proposes that funding should be more directly linked to people's needs rather than places. We propose separating the funding of care and accommodation, and that the limits and numbers of aged care places, both residential and community, be lifted.

The final step in connecting care is improving care for people at the end of life. Our reform directions around improving the care at the end of life focus on expanding access to specialist palliative care, and strengthening palliative care skills in primary health care services, and advance care planning through funding and support of national implementation of respecting patient choices program.

This was one that consumers raised over, and over and over again with us. There's compelling evidence that the use of advance care plans can help people die in a setting of their choice.

Now we move to our third reform direction: facing inequities. In our interim report, we focus on inequities in the health of Aboriginal and Torres Strait Island people, in remote and rural communities, and for people living with mental illness, and in access to dental care, and our boldest reform directions are aimed at tackling these inequities.

First, we face up to the unacceptable and horrific gap and burden of ill health Aboriginal and Torres Strait Island people experience in Australia. We acknowledge the enormous efforts in the last year in the development of a clear way forward to close the gap. It's been a very open and engaging process, and clearly, closing the gap requires big, bold ideas. Importantly, we recognise and agree that closing this gap requires significant action in areas, including housing, education and employment. We're focusing on the 30 per cent improvement that has been suggested can be gained by improving health care delivery. A significant increase in funding is required to achieve this outcome, and the first steps have been committed in the COAG agreements.

The question is we posed, is: how can the extra investment in health care services be most effectively made to make a difference? Our reform proposal is that an expert purchasing function be developed to lead this investment. The Commission believes that this would be achieved by forming a national Aboriginal and Torres Strait Islander health authority as a specialised purchasing function responsible to the Minister of Health. We see this specialised purchasing function as somewhat similar, but not the same as the function in the Department of Veterans' Affairs, which is responsible for purchasing functions for the veteran community, another group for which we consider as special and important in Australia, as, indeed, we believe, are the first Australians.

We're not recommending a change to the providers of health care; indeed, we've recommended strengthening their capacity through other mechanisms. The authority would purchase health services from accredited providers with a focus on achieving outcomes to ensure high quality, timely access, and culturally appropriate care. It would be essential to take the time to engage with Aboriginal and Torres Strait Islander people as to how this purchasing can be best achieved, and to continue the process commenced by the development of the closing-the-gap strategy.

We believe that Aboriginal community controlled health organisations have, and will continue, to play a critical role in the care of indigenous people, and many of these, as you heard yesterday, have set the primary health care standards that the authority will want to model in their purchasing.

From an indigenous health person, and their family's point of view, their choice of, and access to health providers, would remain, and indeed, potentially improve, particularly for hospital care.

We acknowledge that this proposal will change the way that the services are delivered. That's the point. We want better services. We have also recommended strategies for the development of indigenous health work force, and a work force for an indigenous health. We are confident, too, that some of our initiatives in remote and rural communities can also make a difference. These are the targeted recommendations,

other than the main recommendations that you have heard to date, all of which do relate, and have a place in remote and rural health.

To facilitate locally designed and flexible models of care in remote and rural communities, we've argued a more equitable health care requires a more equitable distribution of funding. We, therefore, propose that funding be provided to remote and rural communities based on an adjusted per capita health care spend. This is like an equivalence payment, adjusted for remoteness, for health, and need.

We also recommend an expansion of the multi-purpose service model type service to towns with a catchment of population, approximately to 12,000. Now, these two recommendations are ones that I'm not sure how many times they've been recommended in this forum, but I suspect probably over each of the conferences since 1991.

These two strategies, combined with the commonwealth taking responsibility for all primary health care funding and policy, present a radically different approach to the funding of health care in remote and rural Australia.

Caring for people in remote and rural locations involves either bringing the care to the people, or the people to the care. To bring more care to people in remote and rural areas, we propose an expansion of the specialist outreach services to cover all of the care that's required to bring to people; for example, the medical specialists, the nurse practitioners, midwives, allied health, pharmacy and dental services, to name a few.

We want to encourage a greater and creative use, more creative use of tele-health services, including funding, and to support referral and vice networks, Oncall 24-hour and Internet consultations and advice services, and we want to create a framework, which will allow us to adapt to the technologies which are going to become more available to us into the future.

Attracting and retaining health professionals in the bush is an issue understood only too well by you. What has been demonstrated is that health professionals who are from rural or remote areas or are trained there are much more likely to return or stay there to work.

To tackle some of the distribution issues, we, therefore, propose that a high proportion of new health professional education undergraduate and postgraduate places be preferentially allocated to remote and rural regional centres, and where possible, to multi-disciplinary facilities built on models such as clinical schools or the university departments of rural health. And when it's necessary to take people to the care, the Commission proposes that the patient travel and accommodation be funded at a level that takes better account of the out-of-pocket expenses for patients and their families. Patient travel and accommodation is a big issue, and we've heard a lot about it.

I now turn to another compelling and common example of health inequity: people living with mental illness. The scale of mental illness in our community is larger than we may think, and mostly emerges in teenagers and young adults. It's estimated that 65 per cent of people who need mental health services go untreated, and importantly, we know that young people are particularly reluctant to seek assistance.

Our reform directions in our interim report focus on serious mental illness, and approaches that would extend mental health spending to focus on prevention, early identification and treatment targeted at those most vulnerable.

A range of social support services beyond clinical care are needed to help people suffering from mental illness, and those include employment support and assisted housing; and this is health business. We'd like to see a mechanism that allows greater feedback from consumers and carers when shaping programs and service delivery.

I now move on to the subject that was, not surprisingly to us, on everybody's lips, or in fact closely adjacent to them: I'm talking about oral health and dental care. Oral health is important to your general health, particularly, if you have other chronic conditions, if you're young, you're pregnant, if you're older; it's vital to your ability to speak, eat, smile, and be kissed without pain or embarrassment.

Around 650,000 adults are on the public dental waiting list, and the average waiting time is 27 months. Low-income households spend more than 8 per cent of their total household income on dental health services, and many simply go without. We need a health system with teeth. We're proposing a new scheme—Denticare Australia, to give every Australian universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay.

Denticare Australia would be funded by an increase in the Medicare levy, and will build on access to our private dental care while strengthening our public services.

Driving quality performance and sustaining our work force in the future have been detailed in our interim report. The dedication, diversity and dynamism in our health workforce are our major strength and our major challenge to support them. Because of the long lead time we need to act now to ensure that we have a sustainable quality workforce in the decades ahead.

One of the biggest failures in our health care system is our failure to implement what we already know. If we want to encourage clinicians to focus on the quality of their clinical care and outcomes, we need to provide them with a meaningful and timely data. We propose local systems to support feedback to clinicians, teams in organisations in primary health care, public and private hospitals and aged care. Clinicians should be provided with easy access to the best current knowledge to support their practice, and we've outlined in our report a range of strategies to achieve this. Research is a key enabler of this, and must be better recognised, valued and integrated into the health system.

Governance, or who should run our health system, is without a doubt the single most controversial issue we've been asked to tackle. In our interim report, we have outline three options, and I'm sure you have read them all. This has generated an enormous amount of discussion in Australia, and this is good.

Our final report, due in six weeks, will recommend a preferred model. This is indeed an amazing time. Reform is truly possible. I remain ever optimistic. Thank you for your time today.

## Presenter

**Sabina Knight** is an Associate Professor at the Centre for Remote Health. She is a remote area nurse, with a lifetime career in remote and Indigenous health. Sabina is a foundation member and past president of the Council of Remote Area Nurses of Australia (CRANA), foundation deputy chair and then chair of the National Rural Health Alliance (NRHA) and Chair of Central Australian Rural Practitioners Association (CARPA) editorial committee producing the internationally recognised CARPA best-practice guidelines for remote practitioners and the CRANA Clinical Procedures for Remote and Rural Practice. A recipient of the Louis Ariotti Award, the CRANA Aurora Award and Centenary Medal, Sabina is a Fellow of the Australian Rural Leadership Foundation, the Royal College of Nursing Australia, a member of the Deputy Prime Minister's Regional Women's Advisory Council, the Northern Territory Health Minister's Advisory Council, a director of the board of the Rural Health Education Foundation and a Commissioner on the National Health and Hospitals Reform Commission.