The Health System and Health Reform in Australia

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Some US political similarities
Some US BoD similarities


- Cancer: 19%
- Cardio-vascular: 18%
- Mental: 14%
- Neurological: 13%
- Chronic respiratory: 12%
- Injuries: 7%
- Diabetes: 7%
- Musculoskeletal: 5%
- Other: 4%
- Other: 5%
Reciprocal Health Agreements

- Australians covered for medically necessary treatment in:
  - United Kingdom
  - Ireland
  - New Zealand
  - Malta
  - Italy
  - Belgium
  - Netherlands
  - Norway
  - Sweden
  - Finland

- Citizens of those nations entitled to reciprocal arrangements in Australia
• Commonwealth of Australia Constitution Act (The Constitution):–

  • The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to … pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription) … (s51(xxiiiA))
Main Components

- Public hospitals
- Pharmaceutical benefits
- Medicare benefits
- Private health insurance
- Population health
Main components

Personal health services
  • Health services provided to individuals
  • To treat or prevent illness

Components
  • Hospitals
  • Medical services (Medicare)
  • Pharmaceuticals
  • Disability services and ageing
Main components

Population health services:
- Service provided to populations rather than individuals, often to prevent illness

Components
- Health promotion:
  - media campaigns
- Disease prevention:
  - vaccination
  - Cancer screening
  - Harm minimisation
- Environmental change
  - roads, occupational exposures
Commonwealth roles and responsibilities

- Raises funds via taxation and Medicare levy
- Directly funds
  - Private medical services via Medicare - retrospectively
  - Pharmaceuticals via PBS
  - Veterans’ health services
- Indirectly funds
  - Public hospitals via prospective 5 year grants to States
  - Private hospital medical services via Medicare
- Regulates private health insurance
- Negotiates national health policies with States and Territories
State and Territory roles responsibilities

- With limited tax base, funds and provides:
  - Public hospitals (partially)
  - Mental hospitals (wholly)
  - Community health services (wholly)

- Regulates
  - Health professions: medicine, nursing etc
  - Private hospitals

- Negotiates with the Commonwealth on
  - Hospital funding and
  - National health policies
Commonwealth

- International relations & representation
- Medical benefits
- Pharmaceutical benefits
- Subsidy & regulation of private health insurance
- Subsidy & regulation of aged care
- Funding for population health
- Health promotion (social marketing)
- Veteran’s health

States & Territories

- Public hospitals
- Community health services
- Dental services
- Population health services
- Patient accommodation & transport
- Registration of professionals & premises
Where the money goes (2007/08)

- Public hospitals: 31%
- Private hospitals: 18%
- Medical services: 14%
- Dental services: 8%
- Other health practitioners (paramedics, physiotherapists, psychologists etc): 6%
- Medications: 3%
- Other health (patient transport, community health, public health, aids and appliances, administration, research etc): 19%
Where the money comes from (2007/08)

- Australian Government: 43%
- State/Territory & local governments: 26%
- Private health insurance: 17%
- Individuals: 8%
- Other: 7%
Pharmaceutical Benefits Scheme

- Commonwealth Government subsidy for prescription medicines listed on the Pharmaceutical Benefits Schedule
- Listing requires evidence of cost-effectiveness and applications are assessed by the Pharmaceutical Benefits Advisory Committee
- Government negotiates prices with suppliers of listed medicines
- Patients pay a fixed co-payment per item dispensed (currently $33.30 or $5.40 for concession card holders)
- Medicare Safety Net provides lower co-payments after a threshold number of items has been dispensed for a household during a calendar year.
  - General public entitled to concession rates, Concession holders entitled to no co-payment
Pharmaceutical Benefits Scheme

Pharmaceutical benefits – how they work:

- Negotiated price
- Fixed patient co-payment
- Government subsidy
Pharmaceutical Benefits Scheme

• Established in 1948 to provide essential medicines
  • 140 lifesaving and disease-preventing drugs initially listed
  • Part of wider, though failed, Chifley health reforms
  • Now administered by Medicare

• Since 1987 a rigorous approval process (PBAC)
  • Safety, efficacy assessed by Therapeutic Goods Administration (TGA)
  • Cost-effectiveness assessed by Pharmaceutical Benefits Advisory Committee (PBAC)
    – Usually about $50k/DALY (though can be significantly higher in rare or acute situations with no other alternative treatment)

• Government uses monopsony to minimise costs
  • By negotiating lower prices
  • Encouraging use of generic drugs
    – Brand premium for certain non-generic drugs (patient paid)
    – Pharmacists allowed to substitute generics in “a” listed category medications with patient and prescriber consent (prescriber consent assumed unless “brand substitution not permitted” box checked)
  • Both unpopular with Pharma which claims:
    – “insufficient reward for innovation”
    – threatens viability of local industry
Pharmaceutical Benefits Scheme

• Three types of prescription
  • General (no restrictions on prescribing)
  • Restricted
    – PBAC has determined that treatment is cost-effective only in certain indications/patients.
      » Celecoxib is listed on the PBS as a restricted benefit for the symptomatic treatment of OA and RA. Prescribers using celecoxib for other indications are expected to indicate "non-PBS" on the prescription, and/or the pharmacist dispensing the celecoxib should charge the patient the full cost. Onus on prescribers and pharmacists to identify.

• Authority Required
  – PBAC has deemed that the cost-benefit analysis is favourable only under in specific indications/patients under certain circumstances
  – Phone authority required (doctor’s assertion that condition exists usually taken as sufficient).
  – Prescription must be written on specific Authority Prescription form quoting provider's name and Provider number, patient’s Medicare number and Authorisation number.
Pharmaceutical Benefits Scheme

Commonwealth Government spending on Pharmaceutical Benefits

CAGR = 7.5%
CAGR = 10.4%
Health Insurance

• 1948 Chifley attempted to institute NHS-style public health model in Australia
  • Declared unconstitutional by Supreme Court though PBS retained
• Until 1974 voluntary private health insurance
• 1974 Whitlam introduced Universal Health Insurance (Medibank)
  • Originally to be funded by 1.35% levy on all tax payers with exemptions for low-income earners
  • Public services free, private services subsidised at ‘public rates’
  • Finance bill failed to pass hostile senate so funded through general revenue instead
• 1976 Fraser introduced Medibank Review Committee
  • Findings never made public though Medibank Mk II now funded by 2.5% levy with option of avoiding levy by taking out private insurance
  • Health Insurance Commission allowed to enter private insurance market – “Medibank Private”
  • In 1976 Reimbursement limited to 75% of scheduled fee and limited to concession holders
  • Levy removed and compulsion abolished in 1978
• Rebate reduced to difference between $20 and scheduled fee
• In 1981 free hospital and medical care limited to concession holders only
• 32% tax rebate introduced for private health insurance holders.
Public Health Insurance

• 1984 Hawke government largely rejected Fraser’s direction and moved back towards Whitlam’s model
• Aside from name change no major difference from “original” Medibank (name “tainted” by Fraser)
• Funded by levies on income tax
  • Medicare levy: 1.5% on all earners, with exemptions for low-income
  • Medicare levy surcharge: An additional 1% on high-income earners ($70k+) without adequate private cover
• 1991 Medicare Safety Net introduced
  • Reimburses 80% OOP costs for approved services over $562.90pa (for concession holders) and $1126pa for general public
Public Health Insurance

• Medicare funds medical services
  • Free of cost if doctor “bulk bills”
    – Most common with GPs
    – Rebate $34.30 (+ any procedures performed) for short consult
    – +$7.50 in disadvantaged areas
  • Can be a copayment:
    – Gap between scheduled fee & doctor charges
    – Most common with specialist medical care

• Also funds pathology and diagnostic imaging

• Medicare subsidies recently extended to some nursing and allied health services under “Extended Care Plans” – usually require GP referral
  • Psychologists for mental health care plans
  • ATSI Health Workers
  • Dietitians and Diabetes Educators
  • Limited dental for those with “chronic disease”
  • Some Chiropractic and Physiotherapy for MSK
  • Rehabilitation services (Occupational Therapy, Speech Therapy etc)
• MBS benefits largely restricted to face-to-face doctor services
Medicare benefits:-

• Commonwealth Government fee-for-service subsidy for privately-provided medical services (GP, specialist, laboratory, diagnostic imaging, optometry etc)

• Subsidies are defined by the Medicare Benefits Schedule

• Prices are unregulated - out-of-pocket “gap” charges can arise
Medicare benefits – how they work:

- **Doctor's fee**
- **Scheduled fee**
- **Patient 'gap' payment**
  - Rebate (75% - 100% of scheduled fee)
GRAPH 2 - MEDICARE: Benefits per Capita by State/Territory
2008/09

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Dollars</th>
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<tbody>
<tr>
<td>NSW</td>
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<tr>
<td>QLD</td>
<td>600</td>
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<td>SA</td>
<td>550</td>
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<td>NT</td>
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<td>ACT</td>
<td>550</td>
</tr>
<tr>
<td>AUST</td>
<td>700</td>
</tr>
</tbody>
</table>
Proportion of GP services 'bulk-billed' (no out-of-pocket gap payment)
GRAPH 5 - MEDICARE: Services by Broad Type of Service, 2008/09

- Pathology: 34%
- Spec. Cons: 9%
- G.P. Cons: 40%
- Other: 12%
- Diag. Imag: 6%
GRAPH 6 - MEDICARE: Benefits by Broad Type of Service, 2008/09

- G.P. Cons: 32%
- Other: 29%
- Pathology: 14%
- Spec.Cons: 11%
- Diag. Imag: 14%
Private Health Insurance

- Private health insurance (PHI) supplements coverage under the Medicare Benefits Scheme
- PHI market is heavily regulated:
  - Premium increases must be approved by Minister
  - Premiums are “community rated” (i.e. can’t be adjusted to reflect risk or pre-existing conditions)
  - Insurers must accept all applications for cover
  - Largest Private Insurer is government owned corporation “Medibank Private” – originally non-profit but changing to for-profit in mid-2010 to comply with competition law
- PHI covers hospital costs for inpatient services plus all or some of any “gap” between Medicare Benefits payable and doctors fees charged
  - Greater choice in physician or surgeon
- PHI can also cover “ancillaries” (non-Medicare subsidised services such as dentistry, physiotherapy, CAM, spectacles, gym membership)
Private Health Insurance

• Measures to address falling PHI membership:-
  • Surcharge of 1% of taxable income for higher income earners who do not take out private health insurance (1 July 1997)
  • Commonwealth Government premium subsidy of 30% (1 January 1999)
  • “Lifetime Health Cover” (1 July 2000) -2% premium loading for each year after 30th birthday prior to purchasing PHI (e.g. take out cover at 40 = 20% premium loading)
  • Premium loadings removed after 10 years of continuous coverage
  • Premium subsidies increased to 35% for those aged between 65 and 69, and 40% if aged 70+ (1 April 2005)
  • 2010 Rudd government initiating legislation planning to scrap subsidy for high-income earners ($75k+). Saving ~$700m/yr
Private Health Insurance

Proportion of population covered by private health insurance:

- Medicare introduced
- 1% surcharge
- 30% subsidy
- Lifetime Health Cover
- Higher subsidies for elderly
Hospitals

- Public hospitals “free” (with waiting lists)
- Emergency hospitalisation acceptable at both hospitals (though most private hospitals refer to public)
- Two tiered system for elective procedures
- Queue jumping via private insurance
- Out of pocket expenses can be substantial in private hospitals
- Some mixed
  - e.g. Mater hospitals jointly administered by Sisters of Charity and State government in return for public access provisions
Public Hospitals

• Owned and operated by State & Territory Governments
• Provide a wide range of inpatient (acute & elective), outpatient and emergency services
• Obliged to offer treatment (including pharmaceuticals and other consumables) free at the point of delivery to all eligible citizens
• May also offer private inpatient services (subject to informed choice by patient)
## Public Hospitals

<table>
<thead>
<tr>
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<th>2007/08</th>
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<tr>
<td><strong>Public hospitals</strong></td>
<td>762</td>
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<tr>
<td><strong>Beds</strong></td>
<td>56,467</td>
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<tr>
<td><strong>Overnight separations</strong></td>
<td>2.38 million</td>
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<tr>
<td><strong>Average LoS (excl. same-day)</strong></td>
<td>6.5</td>
</tr>
<tr>
<td><strong>Same-day separations</strong></td>
<td>2.36 million</td>
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</tbody>
</table>
Hospitals

Proportion of Commonwealth Funding of Public Hospitals

Australian Institute of Health and Welfare Health Expenditures 2007-2008
Proportion of patients admitted by service type: Private and public hospitals

Department of Health and Aging *The State of our Public Hospitals Report 2009*
Responsiveness – elective surgery waiting times (2007/8)

Department of Health and Aging The State of our Public Hospitals Report 2009
Responsiveness – emergency department waiting times (2007/8)

![Graph showing median wait times and percentage of patients seen within clinically recommended time across different states in Australia.](image-url)
The Blame Game

Know your Australian flag

Outdated colonial relic

Represents the six reasons the health system doesn't work (and territories)

Navigational aid for boat people

Bit for affixing flag to car

Kudelka. 26/1/2010
The Blame Game

• A complex system
  – “jigsaw” or a “strife of interests”
• Sources of complexity
  – Federal system of Government
  – Public and private sectors
  – Multiple stakeholders
    • Commonwealth and State governments
    • Private health insurers
    • Pharmaceutical industry
    • Organised medicine: AMA
    • Medical schools and Colleges
    • Other health professions:
      – nurses, psychologists
    • Disease advocacy groups
      – Demanding access to expensive new drugs
  • Consumer groups
  • Media etc. etc.
The Blame Game

• The States and Territories say:
  • Public hospital expenses have increased due to inadequate primary care expenditure (e.g. placing more stress on A&E as de facto GP clinics) - Approximately 10% of Australian hospital admissions could be prevented with timely primary care alone.
The Blame Game

• The Commonwealth says:
  • It is being forced to carry cost-shifting of former hospital procedures to outside settings (e.g. between 97/98 and 05/06 chemotherapy costs in hospitals rose 8% while MBS chemotherapy rose 183%; inpatient colonoscopies rose 15% while MBS colonoscopy procedures rose 86%) - Cost-shifting? Or appropriate shift to non-hospital settings?
The Blame Game

Commonwealth
- Open-ended subsidies
- Co-payments
- Maldistribution of services

States/Territories
- Fixed budgets
- Services free at point of use

Patients opt for State/Territory services

Push patients to Commonwealth services
The Blame Game

A health analysts view (Duckett 2004)

• Problems with accountability
  • Dissipation of responsibility
  • Blame shifting
  • Program overlap and duplication

• Economic inefficiency:
  • Cost shifting
  • Gaps in service provision
The Blame Game

• This cost shifting makes it very hard for Australians to tell which level of government is responsible for their health care, and to hold it accountable.

• Patients experience problems when the two parts of the system don’t connect - for example, a patient who is discharged from hospital may not have a good discharge plan that supports their transition back to the care of a GP.
Obstacles to change

- Constitutional change required for transfer:
  - Control of hospitals from States to Commonwealth or
  - Taxation powers from Commonwealth to the States

- Risks to Commonwealth
  - Economic risks of increased expenditure
  - Electoral risks of dissatisfaction with services
  - Organisational challenges

- Opposition of powerful interest groups
  - Organised medicine e.g. AMA, Specialty Colleges
  - States’ rights advocates e.g. among conservatives
  - State politicians’ ambivalence about ceding power
Population Health

- Commonwealth funded and delivered programs:-
  - Bowel cancer screening (MBS)
  - Social marketing campaigns (drugs, alcohol, tobacco etc)
- State/Territory funded and delivered programs:-
  - Health promotion
  - Environmental health
- Jointly funded programs:-
  - Immunisation (MBS/Community Health)
  - Cervical cancer screening (MBS/Hospital)
  - Breast cancer screening (MBS/Hospital)
Population Health

Governments’ spending on population health:

CAGR = 7.4%

- Public health research
- Prevention of hazardous and harmful drug use
- Breast and cervical cancer screening programs
- Food standards and hygiene
- Environmental health
- Organised immunisation
- Selected health promotion
- Communicable disease control
Population Health

- Social marketing an integral part of the Australian healthcare sector since 1970s ($500m+ pa)
  - Life. Be In It
  - “Grim Reaper Ad”
  - “Slip Slop Slap” Skin Cancer Ads
Challenges

• Australia one of the most urbanised nations in the world (with nearly 2/3 of population in 5 major cities)
• Gross inequities between care in urban areas versus regional areas
• Gross inequities between indigenous and non-indigenous populations
<table>
<thead>
<tr>
<th>City</th>
<th>Population (ABS est. 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Sydney NSW</td>
<td>4 600 000</td>
</tr>
<tr>
<td>2 Melbourne VIC</td>
<td>4 100 000</td>
</tr>
<tr>
<td>3 Brisbane QLD</td>
<td>2 100 000</td>
</tr>
<tr>
<td>4 Perth WA</td>
<td>1 650 000</td>
</tr>
<tr>
<td>5 Adelaide SA</td>
<td>1 150 000</td>
</tr>
<tr>
<td>6 Gold Coast QLD*</td>
<td>600 000</td>
</tr>
<tr>
<td>7 Newcastle NSW*</td>
<td>550 000</td>
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<td>8 Canberra ACT</td>
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<td>9 Wollongong NSW*</td>
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<tr>
<td>12 Geelong VIC*</td>
<td>180 000</td>
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<tr>
<td>13 Townsville QLD</td>
<td>170 000</td>
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<td>14 Cairns QLD</td>
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<tr>
<td>16 Darwin NT</td>
<td>130 000</td>
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<tr>
<td>17 Launceston TAS</td>
<td>110 000</td>
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<tr>
<td>18 Albury-Wodonga NSW/VIC</td>
<td>110 000</td>
</tr>
<tr>
<td>19 Ballarat VIC*</td>
<td>100 000</td>
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<tr>
<td>20 Bendigo VIC</td>
<td>90 000</td>
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</tbody>
</table>
Challenges

Responsiveness:

- 9.3% of hospital admissions in 2007/8 were “avoidable if timely and adequate non-hospital care [had been] provided” …

![Bar chart showing responsiveness in different areas of Australia: Major cities, Inner regional, Outer regional, Remote, Very remote. The Australian average is indicated with a red line.](chart.png)
Challenges

Distribution of health:

- There is a clear gradient in life expectancy between urban and rural/remote Australia ...

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
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<tbody>
<tr>
<td>Very Remote</td>
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<tr>
<td>Remote</td>
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<tr>
<td>Outer Regional</td>
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<td>Inner Regional</td>
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<tr>
<td>Major Centres</td>
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</tr>
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</table>

AIHW, Rural, regional and remote health: Indicators of health status and determinants of health. 2008
Challenges

Distribution of health:
- ... which is also evident in relation to health-adjusted life expectancy ...

<table>
<thead>
<tr>
<th>Year</th>
<th>Remote</th>
<th>Regional</th>
<th>Major cities</th>
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<tbody>
<tr>
<td>65</td>
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<td>77</td>
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</tbody>
</table>

Male | Female
Challenges

Distribution of health:
- ... and mirrors similar disparities in health-adjusted life expectancy across socio-economic groups

- Low
- Moderately low
- Average
- Moderately high
- High

Male | Female
--- | ---
Low  |  
Moderately low  |  
Average  |  
Moderately high  |  
High  |  

AIHW, The burden of disease and injury in Australia 2003
Challenges

Distribution of health – Life expectancy for an Indigenous Australian born today is no better than it was for a non-Indigenous Australian born 45 years ago.
Problems with current funding models

- Medicare Safety net resulted in many practitioners inflating prices (even though less out-of-pocket still made them “more affordable”)
  - $0.68 of MSN went to increased specialist fees and only $0.32 to reducing out-of-pocket costs
  - $0.74 of MSN went to increased diagnostic imaging fees and only $0.24 to reducing out of pocket costs – in addition to higher use of services
  - Most MSN went to reducing out-of-pocket expenditures for primary care services

Problems with current funding models

• “Doctor shopping”
  • Doctors remain small business owners with little accountability (performance standards) or integration.
  • Patients remain free to choose their doctor and are often the only source of accessible information on their medical records
  • Over-prescription common, particularly with preventive medications (i.e. patients may be on multiple cholesterol medications), as doctors prescribe “just in case”

• Fee-for-service has led to over-servicing and rorting:
  • Corporatised medicine: Skin clinics, Heart check clinics, fertility clinics
  • Individual medical practitioners: e.g. unnecessary weekly appointments to discuss pathology results
  • Inappropriate practice is defined two-fold:
    – "services that would be unacceptable to the general body of members”
    – Includes the rendering of "80 or more professional attendances on each of 20 more days in a 12 month period", i.e. rorting the system through false services rendered
Problems with current funding models

Middle and higher-income women using private ART and obstetricians ended up being the primary beneficiaries of a safety net designed to help those at the lower socio-economic levels.

Health Reform
Reform proposals

NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION

Goals
• Tackle the major access and equity issues that affect people now
• Redesign our health system to meet emerging challenges
• Create an agile and self-improving health system for future generations

Themes
• Taking responsibility
• Connecting care
• Facing inequalities
• Driving quality performance

123 recommendations
Reform proposals

- Disease
  - Episodic
  - Infectious
  - Trauma
  - Doctor-led
  - Transactional
  - Face-to-face
  - Passive patient
  - Information poor

- Service

- Payment
  - Fee-for-service

- Chronic
  - Multidisciplinary
  - Relationship
  - Remote
  - Active self-care
  - Information rich
  - Pay-for-performance

- Capitation
Workforce Reform

- In 2006 the Council of Australian Governments (COAG) issued a communiqué agreeing to a reform package of the health workforce in Australia
- As part of this package, the National Health Workforce Taskforce (NHWT) was established
- In 2008 the NHWT and COAG agreed to implement the National Registration and Accreditation Scheme for health professionals
- Three stage process:
  - Currently regulated professions in every jurisdiction (by 2010)
  - Currently regulated professions in some jurisdictions (by 2012)
  - Currently unregulated professions (after implementation)
### Workforce Reform

#### Australian Health Practitioner Regulation Agency

<table>
<thead>
<tr>
<th>Currently Regulated</th>
<th>Partially Regulated</th>
<th>Currently Unregulated</th>
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</thead>
<tbody>
<tr>
<td>Medical practitioners</td>
<td>Chinese Medicine Practitioners</td>
<td>Naturopaths?</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>Aboriginal and Torres Strait Islander Health Workers</td>
<td>Speech Pathologists?</td>
</tr>
<tr>
<td>Psychologists</td>
<td>Medical Radiation Workers</td>
<td>Occupational Therapists?</td>
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<tr>
<td>Chiropractors</td>
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<td>Counsellors?</td>
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<td>Osteopaths</td>
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<td>Optometrists</td>
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<tr>
<td>Dental Professionals</td>
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<tr>
<td>Pharmacists</td>
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</tbody>
</table>
National Registration in a Federal System?

• Queensland (the only unicameral state in the federation) has authored the legislation
• Each State and Territory has a “me too” clause in their health legislation
• Changes to this legislation need to be signed off by the Ministerial Council (made up of Commonwealth, State and Territory Health Ministers) which meets at each COAG meeting.
• Some political posturing in relation to Board makeup (1 practitioner member from each large jurisdiction and 1 member guaranteed from one of the smaller jurisdictions)
Structural Reforms

The Commonwealth Government would:

• Become the majority funder of public hospitals
• Take over all funding and policy responsibility for GP and primary health care services
• Dedicate around one third of annual Goods and Services Tax allocations currently directed to state and territory governments to fund changed responsibilities for the health system
• Assign responsibility for managing public hospitals to Local Hospital Networks
• Pay Local Hospital Networks directly for the services they provide, rather than by block grants
Delivery Reform

• GP Superclinics
  • The Bridge between private primary care and hospital services – tailored for local communities
  • Combines federally and state/territory funded private medical and allied health practitioners, nursing staff, community health and health promotion initiatives under one roof
  • New triage methods (i.e. GPs skills not “wasted” on unnecessary gatekeeping)
  • Training environment for new workforce
  • Multidisciplinary focus
  • Broadly similar to some of the community health centre reforms in recent legislation
Acknowledgements

Special thanks to:

• Professor Phillip Davies
• Greg Fowler
• Professor Wayne Hall
Who knows where next?