Assessment and recommendations

Australia's health system functions remarkably well, despite operating under a complex set of institutions that make co-ordinating patient care difficult. Complications arising from a split in federal and state government funding and responsibilities are central to these challenges. State and territory governments are the managers of public hospitals, while the federal government has primary care stewardship. This fragmented health care system can disrupt the continuity of patient care, lead to a duplication of services and leave gaps in care provision. Difficulties in co-ordinating patient care are exacerbated further by an unusual split in responsibilities across primary care and community health. The federal government is responsible for "primary care" largely in the form of reimbursing general practitioners (GPs), while the states and territories oversee "community health" such as maternal and child health services. Additionally, state-run public hospital emergency departments provide primary care, particularly for people who cannot access primary care services outside standard working hours. Supervision of these health services by different levels of government can manifest in avoidable impediments such as the poor transfer of health information, and pose difficulties for patients navigating the health system. Adding to the Australian health system's complexity is a mix of services delivered through both the public and private sectors.

To ease health system fragmentation and promote more integrated services, Australia should adopt a national approach to quality and performance through an enhanced federal government role in steering policy, funding, co-ordination, priority setting, performance monitoring and assessment. The states and territories, in turn, should take on a strengthened role as health service providers, with responsibility for primary care devolved to the states and territories to better align it with hospital services and community health. A more strategic role for the centre should also leave room for the strategic development of health services at the regional level, encouraging innovation that is responsive to local population need, particularly in rural and remote areas. This could be considered as Australia undertakes a national conversation about the roles and responsibilities federal and state and territory governments should adopt in a range of areas, including the division of responsibility in health care.

Australia has a universal health system funded through the Medicare scheme introduced in 1984. It is mostly financed through taxation and entitles Australians to free care as public patients in public hospitals. In primary care, about 80% of consultations with GPs come with no out-of-pocket cost to patients. At 82.2 years, life expectancy is the sixth highest in the OECD. Australia has one of the lowest smoking rates in the world, and its heart disease and cancer mortality rates are below the OECD average. With health expenditure at 8.8% of GDP, Australia achieves good health outcomes relatively efficiently. Significant progress in national approaches to quality and safety has been made in recent years, including the introduction of the National Safety and Quality Health Service (NSQHS) Standards that all hospitals must meet to attain mandatory accreditation. The standards were developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and have been well received by stakeholders, with broad agreement that they promote greater clinical involvement and more directly address specific and fundamental areas of safety such as clinical handover.

The regulation of health professionals has also undergone significant reform, and the changes have made Australia a leader among OECD countries. The national system for the regulation of health practitioners in 14 professions includes annual registration linked with compulsory continuing professional development requirements, and a website that consumers can use to verify the registration status of individual health professionals. As part of a culture of improving health system transparency, Australia has created the "MyHospitals" website that provides public and private hospital-level data on a range of indicators ranging from emergency department waiting times to rates of infection. Measures of performance of primary care are published on the "MyHealthyCommunities" website, which provides local-level data on a range of primary care and population health performance indicators. The National Health Performance Authority (NHPA) is responsible for the analysis and content of these two websites.

Australia, however, is facing the profound challenge of trying to combat rising chronic disease. With more than a quarter of people aged 15 and over obese, Australia is the fifth most obese country in the OECD. This rise in obesity will inevitably extend to a growth in diabetes and other preventable chronic conditions, making strengthening public health and primary health care a priority. The lack of flexibility in payment systems, with a heavy focus on reimbursing doctors through the current fee-for-service system, is another barrier to promoting quality of care for these more complex patients. Other challenges in the Australian health system include:

- Relations between federal and state and territory governments can sometimes be strained, and this is particularly acute when political sensitivities arise over the federal government's contribution to hospital funding. There are frequent claims of cost-shifting, particularly concerning primary care patients (overseen by the federal government) attending hospital emergency departments (overseen by state and territory governments);
- There is a significant maldistribution in the health workforce. While governments have progressively increased the number of medical places in universities, there remains a heavy reliance on overseas-trained doctors. Workforce shortages are particularly acute in rural and remote Australia;
- Access to health care in Australia's most remote parts persists as one of the country's most daunting challenges. Australia has made efforts to be creative in this regard, but has yet to fully realise the potential of technologies and flexible payment systems that are necessary to drive innovation;
- Significant differences between non-Indigenous and Aboriginal and Torres Strait Islander people persist, including a 10-year life expectancy gap. Despite the efforts of successive governments, the latter group continues to experience significantly poorer health outcomes;
- The uptake of electronic health has been slow and disappointing, in part due to the existence of an opt-in system (an opt-out system is being trialled), a lack of public awareness, and the absence of health system infrastructure and internet technology in some places;
- A surprising lack of data on the quality and outcomes of care marks out Australia from its peers. This is particularly the case for primary health care, which has an under-developed pay-for-performance scheme, and for rural and remote health care. There are few indicators promoting quality of clinical care and patient outcomes, and there is little opportunity for GPs to be benchmarked against their peers;
- The high rates of avoidable hospital admissions for asthma and obstructive pulmonary disease also indicate the need to strengthen primary health care to more promptly and effectively accommodate the needs of patients long before their conditions deteriorate and require hospitalisation.

If Australia is to be in a better position to respond to the growing numbers of patients with multiple chronic conditions, it should build on its strong tradition of GPs to develop a primary and community care "eco-system" around them, characterised by co-ordinated care supported by a strong data collection and monitoring culture, and innovative and flexible payment systems. This should be bolstered by ramping up the measurement of quality of care delivered in the community. Models that Australia could learn from include the "medical home", and Portugal's family health clinics, where multidisciplinary teams provide community support and primary care. It is welcome that Australia is exploring policy levers to enhance the role of the GP as care co-ordinator for more complex patients, by permitting those who meet prescribed criteria to voluntarily enrol with one primary health centre. Under one such trial, the Diabetes Care Project, clinics are given incentives to offer patients with diabetes a range of services by a multidisciplinary team. The trial's evaluation should inform policy making towards supporting the multidisciplinary management of chronic disease and integrated primary health centres.

Strengthening primary health care

Responsibility for primary care in Australia rests predominantly with the federal government. Australia has a long-established tradition of GPs working in private practice as patients' first point of call. Patients do not have to enrol with a GP, and can attend multiple doctors should they choose to do so. GPs act as health system gatekeepers, providing referrals to specialists when necessary. Doctors are allowed to set their own fees, and patients are subsidised towards the cost of these services through the Medicare fee-for-service system.

Despite being the gateway to the health system, GPs are not supported to take on the role of care co-ordinator

Australia is fortunate to benefit from a long-established tradition of general practice doctors. Australia ranks highly among OECD countries in the extent to which this category of professionals is a major part of the medical workforce. This tradition provides Australia with a natural leader in the supervision and provision of primary care and a focal point through which care can be co-ordinated.

However, GPs do not necessarily work in an institutional environment that supports them to play this role. They are often in small practices that limit opportunities for modest specialisation, devolving or sharing tasks among their peers or with other health professionals. There is poor communication between GPs and other health care professionals,

particularly those in hospitals. This is partly driven by the fragmented nature of the health system and the under-use of electronic health to exchange important information about patients.

Primary care and community health services ought to be brought together under one level of government, with responsibility for primary care devolved to the states

There has been a trend toward the consolidation of GPs in larger practices, and in many cases a move to horizontal integration alongside allied health professionals. The structural shift towards the consolidation of doctors and other health professionals under one roof is leading to a diversification of the services offered by clinics, such that they are increasingly duplicating services that have been considered "community health" in Australia. This distinction between "primary care" and "community health" is unique to Australia, and complicates planning across services that work closely together in other OECD countries. The former is led by GPs and has federal government oversight. The latter falls under the responsibility of the states and territories, and consists of specialist services in the community such as child and maternal health and drug and alcohol services.

Ensuring co-operation across the two levels of government responsible for health care has been a long-running policy challenge in Australia. No other OECD country shares such a separation of functions of services. Broad historical considerations under federal and state financial relations – rather than a compelling health policy rationale – led to the federal government paying GPs and state governments paying community health services. This separation unnecessarily complicates national efforts for policy alignment and local efforts to co-ordinate services to be convenient and accessible to the patients that need them.

Australia should consider removing the distinction between primary care and community health, and handing responsibility for all primary care services to the states and territories, to improve the interface with hospital services. Under such a move, the federal government would continue to play a pivotal steering role in policy, funding, priority setting and performance monitoring, while the states would act as regional commissioning agencies for health care in Australia. The co-ordination of care would be promoted for patients moving between state-managed acute hospitals and community health services, and primary care services.

The federal government has proposed aligning new Primary Health Networks with existing local hospital networks. These networks could be building blocks supporting further structural and funding reform that bring

more responsibility for service delivery to the states. Such significant reform would be courageous, and require a major upheaval of federal and state financial relations, and a careful consideration of the transition and management of risk given the current open-ended nature of the Medicare system. It will also require a sincere willingness by the federal and state governments to work co-operatively to achieve health system reform that will improve the integration of health services and the patient experience. The Primary Health Networks could help facilitate this transition, bringing greater responsibility for service delivery to the states and territories.

While having many of the characteristics of a strong primary health care system, Australia is falling behind many OECD countries in monitoring quality in primary care

Today, there are very limited means by which Australian doctors working outside hospitals can get relevant clinical indicators on their work, let alone any significant capability to benchmark the care they provide with their peers. This reflects the combination of challenges experienced by the federal government to effectively manage primary care performance, and the reluctance of GPs to collect this information. To some extent, the collection of data and benchmarking has already been taking place through initiatives such as the Australian Primary Care Collaboratives programme, which aims to help GPs and primary care providers work together to improve patient clinical outcomes, reduce lifestyle risk factors, help maintain good health for those with chronic and complex conditions, and promote a culture of quality improvement in primary health care. This is also being achieved through the efforts of local doctors, although greater scale is required for such indicators to be meaningful.

At the same time, there is a lot that federal and state and territory governments can do to better share the information they collect, beginning with basic information about the use of health care services. The prospect of linking state hospital records with Medicare data would provide doctors with a reliable patient information history upon which clinical notes could be added in the future. While this in some respects is the ambition of the electronic health record, the poor take-up to date suggests more compulsive policies should be considered to get patients and health services to participate. The government should revitalise the strategic intent to establish electronic health records for patients, ensuring sufficient population coverage and depth of information for specific patient groups to enable meaningful clinical support and quality measurement over the pathway of care.

Changing how health care is financed can go a long way to giving primary care practices more flexibility in how they operate

When compared with OECD countries, it is surprising that the consolidation of practices in Australia has occurred despite a payment system that reimburses additional volume by doctors, and does not necessarily compel a patient to have a continuous relationship with their doctor. Physicians paid on a fee-for-service basis generally have an incentive to see more patients and to provide more services than salaried physicians, since their income is linked with the volume of services. Fee-for-service comes with the benefit of being simple and rewarding productivity. However, the tendency towards higher volumes can be moderated through a greater proportion of funding linked to outcomes.

Australia's Practice Incentives Programme (PIP) links general practice financial incentives to 11 indicators. However, only five indicators reward processes associated with quality of care or patient outcomes. This is very limited in comparison with the efforts of the United Kingdom, which has sought to develop a comprehensive series of indicators that reach more aspects of clinical practice. While Australia supports such quality indicators for asthma, diabetes, cervical cancer, quality prescribing and Indigenous health, other countries include screening of other cancers, immunisation, child and adolescent health, and cardiovascular diseases.

Australia should take advantage of the structure of services in primary care to lessen the reliance on fee-for-service payments. A more robust blended payment system could considerably build on the PIP, with a view to rewarding processes associated with more indicators of quality of care and better patient outcomes. At a minimum, this could be through demanding the collection of better measures. This could be financed through further slowing or redirecting funds paid through fees. The creation of a performance framework in which GPs report on a broader range of indicators would also provide a mechanism for GPs to be benchmarked against their peers. Peer comparison and public scrutiny can be strong incentives to lift performance. Eventually, Australia could emulate the United Kingdom in moving to a system of public reporting on these indicators, with performance data at the individual general practice level available on a website. The current trend towards the consolidation of practices should enable the government to reasonably seek that GPs collect information on a greater array of indicators.

Quality-related payments should be made to a practice, rather than individual clinicians, wherever possible. This gives these institutions the means to ensure funding can be directed to what they consider their priorities to be. It also gives freedom to doctors to collectively decide

whether budgets from quality-related payments should be directed to practice nurses, engaging specific allied health professionals, or providing an enhanced range of services including better prevention. These decisions can be made based on the unique needs of their communities. Such a model should be developed in a gradual manner, so as not to move towards large-scale budget holding by GPs or practices, but rather play a supplementary role.

Policies should continue to support the development of team-based GP care

The trend toward a more multidisciplinary approach makes it easier for patients to draw on the services of various health practitioners. For the most part, this move towards larger practices has been driven by changes in the preferences of doctors and health professionals, as it allows for the easier delegation of tasks and opportunities to work in teams. It has also been supported by economic efficiencies from sharing administrative functions. The federal government has helped to nudge this trend with a number of policies. This includes providing small capital grants for infrastructure and support for practices to employ nurses. Accordingly, there has been a growth in practice nurses assisting GPs in their work.

The PIP's focus on paying practices rather than individual doctors has also facilitated this trend, although these incentives account for less than 10% of overall spending on primary care. To access these incentive payments, general practices must attain accreditation. This is more cumbersome for solo practitioners, and makes it economically advantageous to move to bigger clinics to share accreditation costs. About 75% of general practices in Australia participate in accreditation. There is scope for the government to identify the barriers to accreditation and support all general practices – particularly small practices – to move towards mandatory accreditation as a quality assurance measure.

Safety and quality standards and monitoring

Over the past two decades, Australian policy makers and clinicians have developed a nationally agreed set of standards on the safety and quality of care that apply to every hospital in the country. Currently, the basis for health service accreditation in Australia is the NSQHS standards, developed by the ACSQHC. These cover ten priority areas: governance for safety and quality; strategies for partnering with consumers; the prevention and control of health care-associated infections; medication safety; patient identification and procedure matching; clinical handover; the safe management of blood and blood products; prevention and management of pressure injuries;

recognition and response to clinical deterioration in acute health care; and the prevention of falls.

Australia's delivery of a set of national standards for all acute health care facilities is a leading example of quality of care improvement efforts in a federated country

The NSQHS standards and accreditation scheme represent important elements of the overall safety and quality improvement architecture of the health system. The development of the scheme and standards took five years. The nature and level of input afforded stakeholders in the development process appears to be one of the key factors facilitating its broad acceptance. The standards address well established and universal quality issues for health services. There has been broad agreement from stakeholders that the new standards are a positive move forward, promoting greater clinical involvement and more directly addressing specific quality issues than other standards. The standards are acute-care focused, and it is acknowledged that further development is required to effectively apply the standards to non-hospital care, including primary care, aged care, mental health care and community care and support.

The origins of this work lie in a landmark study on quality in Australian health care, which found that an adverse event occurred in almost 17% of hospital admissions studied. About half the adverse events were preventable. Since then, governments and the clinical community have slowly stepped up efforts so that every hospital is today accredited against these standards. Having achieved these service standards, the challenge for Australian policy makers now is to develop increasingly robust metrics linked to their implementation and impact, ensure that standards remain relevant to quality and safety priorities and to apply them beyond hospitals. The standards form the building blocks for a national approach to quality assessment and improvement.

While it is understood that all public and private hospitals and day procedure centres are required to be accredited against the standards, there remain unresolved issues regarding private hospitals. While private health insurance arrangements and state government roles in regulating private hospitals enable the mandating of the new standards, the state regulatory role requires application of licencing standards. This presents the possibility of duplication, which needs to be addressed through greater harmonisation of licensing and accreditation arrangements.

Expanding the scope of the national standards

Government policy makers are seeking to develop appropriate standards for other health care facilities. Future efforts will include aged care and mental health services, which today all have separate standards and accreditation processes. There is scope for actions and indicators used to monitor adherence to the standards to be aligned, consolidated and, where necessary, expanded.

Strengthening governance with fewer, stronger authorities

The ACSQHC is demonstrating national leadership in co-ordinating health care safety and quality improvements in Australia. The federal government should clarify the ACSQHC's role in the overall quality improvement and governance arrangements for the health system, particularly in relation to the assessment and management of hospital performance. The ACSQHC, which develops and maintains the acute case-focused NSQHC standards, could take on a broadened role in the governance of quality standards, in seeking to improve consistency and coherence of quality and safety standards across acute, primary care and support, aged care, disability and mental health sectors.

The ACSQHC is the principal national agency for leading safety and quality improvement, but other agencies also have different but overlapping health care quality functions including oversight and reporting. The architecture at the national level is unnecessarily complex. The government should review the roles and responsibilities of other existing national bodies centrally involved in the governance of health service quality and performance, with a view to identifying opportunities for role clarification and consolidation. The government has proposed to establish a new Health Productivity and Performance Commission. The consolidation of quality and performance oversight might present an opportunity to ease some of the health system complexity, and bring consistency and greater coherence to these activities.

Building stronger monitoring infrastructure

Tackling appropriateness of care can potentially improve outcomes while producing efficiencies. The overuse, underuse and misuse of health services are critical issues for research and policy on quality of care, and highlight the need to strengthen the policy focus on the appropriate use of health services.

A number of Australian studies continue to demonstrate significant and unwarranted variations in medical practice across the country. These include

the Care Track Study, which found that adults in the study sample received appropriate care, in accordance with evidence-based or consensus-based guidelines, 57% of the time. This study highlights that the provision of highly variable and often inappropriate care remains a national problem. Further evidence exists in a study by the ACSQHC supported by the Australian Institute of Health and Welfare (AIHW), undertaken as part of an OECD analysis on medical practice variation. Variation between Australian local areas was evident across all interventions and conditions. There was also wide variation compared with other countries. For example, hospital non-surgical admission rates were twice as high in Australia, at about 12 000 per 100 000 population aged over 15 years, than in Spain, Portugal and Canada, where they stood at below 6 000. Australia also had one of the higher rates of variation within the country, and some of this was explained by extreme values, with very high hospital medical admissions rates in three local areas. It is encouraging to see the ACSQHC is developing an Australian Atlas of Health Care Variation to examine a broader range of health care interventions. However, it is important that the Atlas stimulates genuine action to address any areas of unwarranted variation through specific and targeted quality improvement initiatives.

Australia remains behind other countries in evaluating the effects of health care services on influencing patient outcomes and using this to drive policy. There are currently only a few national registries, including those covering joint replacement, intensive care, renal dialysis and various forms of organ transplantation. By contrast, in Sweden, registries can cover up to 70 areas, and are used to inform guidelines and clinical practice improvements for procedures where there are large variations in processes or outcomes of care that have a significant impact on overall health care costs and patient morbidity. This includes cardiac procedures involving angioplasty and stenting.

To augment the national standards, clinical registries for quality improvement should be developed.

Learning from good practices within the country

Considerable effort has gone into developing the NSQHS standards. However, there exist few formal mechanisms by which clinicians and managers can learn from their peers. Awareness of the formal mechanisms that do exist for health services to compare and contrast their performance and participate in detailed benchmarking relationships is limited.

Apart from hospital executives, many stakeholders appear to have limited knowledge of established agencies and processes in place, such as the Health Round Table and the Primary Care Collaboratives programme.

Clinicians, in particular those involved in primary care, have expressed a desire and willingness to be further involved in peer review mechanisms in relation to safety and quality. If the government proceeds with the proposal to establish a Health Productivity and Performance Commission, there is scope for it to not only support the rollout of and adherence to standards, but promote and facilitate the sharing of innovations to improve health care safety and quality.

Additionally, the ACSQHC has done work on variation in health care provision, and on Clinical Care Standards. These standards describe the minimum elements of care for a particular condition or intervention. Three standards have been developed by the ACSQHC; acute coronary syndrome, stroke and antimicrobial stewardship. Development of further standards is strongly encouraged to address areas where significant practice variation exists, and impact on health outcomes and service costs is significant.

Trialling models for integrated financial incentives for quality and safety improvement

Australia has adopted a national approach to activity-based funding for hospitals, with a pricing policy based on underlying principles for improving the technical efficiency of service provision. There is scope to explore funding mechanisms to improve health care quality and safety. The Independent Hospital Pricing Authority (IHPA), which is responsible for the pricing framework for public hospitals in Australia, has been working with the ACSQHC to explore options to take into account safety and quality in the pricing of public hospitals.

The requirement for hospitals to publicly report on a range of indicators is an incentive to improve health system performance. Incorporating quality into pricing could be another performance incentive for consideration. Queensland and Western Australia are examples of Australian states that have already gone down this path. Queensland authorities withhold payments for six “never events”, which include procedures on the wrong patient or body part resulting in death or major permanent loss of function, and retained material after surgery requiring further surgical intervention. Queensland has also defined adverse events for which there are reduced payments to hospitals, and offers quality improvement payments. Western Australia gives incentive payments for best practice in areas such as fragility hip fracture treatment, stroke unit care, and acute myocardial infarction treatment. Eligible hospitals receive a payment for each patient who received “best practice”.

The experiences of these states can be used to inform national policy on the pricing for quality and safety. Australia should progress investment in

and evaluation of national approaches to providing financial incentives for quality and safety improvement. This should include pricing structures that allow clinical services to participate in clinical quality registries, linked to clinical benchmarking.

Mechanisms should be in place to mitigate the risk of the deliberate manipulation of hospital data to acquire incentive payments.

Improving the quality of care in rural and remote settings

Australia's geographical vastness adds another dimension of complexity to its health system and poses unique challenges for health service delivery. In some communities, people may live hundreds of kilometres from their nearest major centre, with limited transport and unsealed roads making travel difficult. Existing medical conditions can be compounded by socioeconomic disadvantage and insufficient services in Australia's most remote parts. These policy challenges place Australia in a unique position in which it needs to be innovative, giving it the potential to be a leader among OECD countries. Such innovation requires further workforce reform and the continued exploration of new integrated care models. This can be achieved only with strong governance, flexible payment systems and a willingness to overcome resistance to change. The Earned Autonomy model in the United Kingdom, where high-performing health services are given greater freedom to be innovative, is one Australia could consider.

Australians in rural areas experience poorer health outcomes and challenges in accessing services

People living in cities can expect to live longer than people in more remote areas. Men living in major cities and inner regional areas can expect to live 2.3 years more than men in outer regional, remote and very remote areas combined. For women, the life expectancy gap is 1.4 years. These differences are only partially explained by the higher proportion of Aboriginal and Torres Strait Islander people in more remote areas, as the poorer state of health extends to non-Indigenous people in remote Australia.

Rural Australia has higher mortality rates associated with cancer and other chronic disease, a higher prevalence of mental health problems, more potentially preventable hospitalisations, and higher rates of injury. The overall mortality rate is 5.5 per 1 000 people in major cities, compared with 8.4 in very remote areas. Potentially avoidable hospitalisations number 11.1 per 1 000 people in major cities, compared with 27.3 in very remote areas. More concerning are the statistics that apply to Aboriginal and Torres Strait

Islander people, who trail non-Indigenous people on a range of health outcomes.

The regional disparities in life expectancy in Australia are considerable when compared with other OECD countries. Australia has the third highest regional disparity in life expectancy in the OECD, with a difference of 6.1 years between the Australian Capital Territory (life expectancy at birth in 2010 of 82.6 years) and the mostly rural Northern Territory (76.5 years). Only the United States (6.7 years) and Mexico (7.1 years) have greater regional disparities in life expectancy. It is difficult to disentangle how much of this relates to lifestyle factors, but there is no doubt that people in remote areas have greater difficulty in accessing health services.

There are considerable disparities in the density of the medical workforce across the country

Workforce shortages are a challenge in rural and remote Australia in a way that few OECD countries have experienced. Australia relies considerably on overseas-trained doctors to meet rural health workforce needs. Some 30% of medical practitioners practising in Australia obtained their first medical qualification in another country. In rural areas, the figure is around 50%. Federal government policy has sought to direct overseas-trained GPs to more remote areas to fill workforce gaps. Overseas-trained GPs in Australia make up a higher proportion of the GP workforce in regional and remote areas and account for less of the workforce in major cities.

Australia has made attempts to embrace innovation to boost local workforces

In addition to increasing the number of Australian-trained doctors, Australia has experimented with a greater array of policies to improve the distribution of its medical professionals than almost any other OECD country. A rural generalist programme enables GPs to be upskilled so they can perform some specialist roles including anaesthetics and obstetrics. The programme has expanded, and there is scope for the creation of more of these positions through rural generalist training pathways. This could help rural communities become more self-sufficient. The possibility of adding more specialist functions onto the role should be explored. There is also scope to extend these rural generalist roles to nurse practitioners, by upskilling nurses already working in these areas.

Recognising that increasing numbers alone can only go so far, policy makers have started to catch up with other OECD countries to make more use of health professionals other than doctors. The expanded roles for nurse

practitioners, psychologists and other health professionals are welcome. In the case of nurse practitioners, their numbers remain small in Australia. Barriers to nurses choosing to move into nurse practitioner positions should be investigated. Additionally, there is an opportunity for paramedics, pharmacists and other allied health workers to play a bigger role. Australia should continue to support changing scopes of practice and the creation of appropriately regulated new roles. Practice models need to be innovative, with more scope and greater diversity.

Another strategy Australia has adopted is to offer doctors financial incentives to move to areas of need. The poor take-up of some rural relocation incentives, despite two waves of reform, reinforces the international evidence base suggesting that financial incentives are often limited in their capacity to change preferences for where doctors work.

The more recent combination of increasing the number of doctors in training and introducing more compulsive policies for rural service should be given the years needed to have their effects felt and to be evaluated.

There has also been a growth in rural medical schools, and Australia should continue to explore ways to build the capacity of local health workforces with medical schools that are closer to home. Many Australian universities have taken the lead in encouraging student doctors to gain experience in rural areas. There is scope to make this obligatory, for instance in the form of compulsory rural rotations as part of medical internships. In recognition that working in rural areas can be isolating, there is a need for stronger support for rural health practitioners to undertake continuing professional development near where they work, giving them an opportunity to network and share knowledge with their peers.

Innovation in rural and remote areas needs to be accompanied by strong governance and flexible funding models

Both federal and state governments have an array of programmes to support care in rural and remote areas, but the highly conditional way in which they deliver funding often does not fit the non-conventional operational models that exist in rural areas. For example, rural GPs often see patients independently and are reimbursed by the federal government. They later become the consulting physician in an emergency department and negotiate a salary or payments from state authorities.

More flexible models of care need to be accompanied by strong governance and a more flexible approach to funding. Changing scopes of practice need to be supported by payment systems encouraging health practitioners to upskill and adopt different roles. Australia already allows

nurse practitioners to receive Medicare funding for a limited number of tasks under tightly regulated conditions. The expansion of access to Medicare funding can be considered a possible tool to encourage appropriately qualified and trained health practitioners to embrace other roles. For example, pharmacists in areas of need could be eligible to receive Medicare funding to administer vaccines and prescribe limited medications. Such a move should be carefully regulated and done in a fiscally responsible way.

Funding models for rural health services should be developed that sustainably reward quality and outcomes. Rural communities should be provided health services using block funding wherever practicable, as the low volume of patients in small rural hospitals makes activity-based funding infeasible. Federal and state governments should work towards developing flexible funding models that are responsive to local need. One model for funding care for chronic conditions is prospective block grants contracted on outcomes. These enable the payer to specify the outcomes it wishes a care provider to deliver, while allowing the care provider flexibility in how services are designed to deliver those outcomes. Australia is already experimenting with advance payments for bundles of care for patients with complex needs in its Diabetes Care Project. The trial's evaluation should inform future policy.

Federal and state governments should co-ordinate on service planning for regions of medical workforce shortage. This will oblige both levels of government and their respective policy makers to try to develop a more meaningful assessment of the needs of these communities and tailor their ways of paying them to suit the maintenance of needed services. The location of federally-funded "multi-purpose" facilities can help supplement services in communities but may also instigate disinvestment by state governments in hospitals or appropriate transfer arrangements.

More investment is needed in getting patients to acute services and linking these services to patients via technology

It is not uncommon for specialists and other health practitioners to be flown in and out of remote areas to deliver health services in communities where it is unviable to have a full-time specialist, or where specialists do not want to live. This medical outreach is expensive but has become a vital part of health service delivery in Australia's most remote parts. Such schemes work best when a visiting specialist pairs with a local GP to manage a patient's care. Outreach specialists should be encouraged to act as mentors to local GPs, to share knowledge and encourage continuity of a patient's

care when the specialist leaves, forging stronger links between rural and metropolitan health service providers.

Health technology can facilitate these links. There is a need to maintain investments in technologies to help overcome geographical challenges to care. Telehealth is a very promising innovation in Australia and internationally, using technology to link patients or GPs in rural areas to specialists in regional centres or major cities. The benefits of telehealth include access to a larger pool of specialists. Patients who are unwell are spared the inconvenience of travelling long distances. As new evidence emerges, there is scope to expand the use and coverage of telehealth across medical conditions and geographical areas. For example, there is potential for telehealth to link rural GPs working in partnership with specialists in radiology and oncology, and the development of models making greater use of nurse and allied health generalists in the rural workforce. Flexible payment systems are necessary to achieve this.

Strategies that boost local workforces and augment their use through changing scopes of practice and the use of technologies could potentially reduce the need for more expensive outreach services. While being respectful of social preferences relating to how funds are spent, Australia ought to consider whether certain outreach services that are funded today could be better spent through other means, given their high unit costs.

In cases where health care close to home is not possible, patients in remote areas may need to travel to receive treatment in an acute hospital setting. Patient travel assistance programmes managed by the states subsidise the travel and accommodation costs of patients who need to travel long distances for medical care. However, these programmes should be better subsidised to more accurately reflect the real cost of travel and reasonable accommodation. There are significant inconsistencies across the states in terms of eligibility criteria and payments. Efforts should be made to move to a more nationally consistent scheme.

Quality-focused governance should be embedded in all rural and remote health services. Quality measurement should be applied to clinicians who visit on an ad-hoc basis. This includes benchmarking against equivalent metropolitan services, patient opinion surveys, and root-cause analyses of adverse incidents and patient complaints.

Little is known about the quality and outcomes of care delivered in the large number of small hospitals in Australia, and this is a cause for concern

Australia's high number of hospitals is largely due to the existence of many small hospitals or hospital-like facilities. While this is undoubtedly a feature of geography and a social preference to maintain the availability of certain clinical services, very little is known about the quality of care delivered in these hospitals.

More broadly, there is insufficient information about a number of quality indicators by remoteness, such as sentinel events and adverse events, and on mental health services. The collection of more robust quality data would facilitate the identification of high-performing health services that could be granted more flexible funding and autonomy to create innovative programmes designed to serve local population need.

There is also a lack of data to inform the health care need in many remote communities. The Australian Health Survey excludes people in very remote areas, making it difficult to directly compare their health service usage with people living in other areas. Publishing indicators of quality by remoteness can help guide the health sector to where the greatest challenges lie. Australia should develop a stronger information system by investing in extending its basic information set on health service needs, service use and outcomes to include remote areas consistently.

With regards to data on the Australian health workforce, there is a wealth of information measuring the scope of the current workforce, but a scarcity of projections measuring future shortages by health profession and location. The existence of this depth of information would help Australia meet its goal to have a more self-sufficient health workforce.

Recommendations for improving health care quality in Australia

Australia has a world-class health system with lessons for other OECD countries. Innovations around the registration of health professionals and national standards for health services are particularly noteworthy. To ease the complexity and fragmentation of the health care system, the federal government should take on more of a steering role, with responsibility for health service delivery including primary care devolved to the states. Improved data collection and flexible payment systems are also required to promote innovative ways of delivering high-quality care. This should all be underscored by strong governance. For Australia to be best placed to respond to the challenges associated with a rise in chronic disease, and to bolster the quality of the health system, it should:

1. Strengthen quality of care policies, governance and information infrastructure

- Strengthen health care quality governance with a clearer national steering role for the federal government with regards to policy, funding, co-ordination, priority setting and performance monitoring and assessment.
- Consolidate and strengthen the responsibility for quality reporting and benchmarking, forums for sharing learning across peers, and strategies for identifying and diffusing innovation.
- Strengthen efforts for quality indicator development and national reporting to satisfy existing ambitions under the National Health Reform Performance and Accountability Framework and establish new indicators in priority areas, particularly indicators to support each of the national safety and quality health service standards.
- Improve public reporting by adding more hospital-level quality data to the MyHospitals website, including adverse events and the results of patient experience surveys.
- Revitalise the strategic intent to establish electronic health records for patients, ensuring sufficient population coverage and depth of information for specific patient groups, and move to an opt-out system.
- Bring forward investment to establish a set of national quality registries to address key gaps in clinical indicator data required to underpin quality standards and enable national reporting and benchmarking.
- Trial methods and systems to enable the use of hospital administrative data to monitor adverse events, to support quality monitoring and improvement at national level.
- Assess options for the development of a database (including the Department of Health Enterprise Data Warehouse) to provide a national repository of intelligence on hospital quality, including capacity to benchmark information at service level.
- Progress investment in and evaluation of national approaches to providing financial incentives for quality and safety improvement.
- Explore options for greater patient involvement in making decisions about their local health services. Develop a nationally consistent and culturally inclusive patient experience survey for all public and private hospitals.

Recommendations for improving health care quality in Australia *(cont.)*

2. Strengthen primary health care

- Align priority setting, funding and performance management of primary care with that of community health services and hospitals. Consider devolving responsibility for primary care to the states and territories, as unified commissioning agencies for all health care services in Australia.
- Use Primary Health Networks as building blocks to future reform, and ensure they have in place appropriate clinical governance arrangements and are subject to mandatory accreditation and public reporting.
- Build an eco-system around GPs to improve the co-ordination of patient care and promote the GP's role as co-ordinator, including the creation of more primary health centres with multidisciplinary teams.
- Build on the Practice Incentives Programme to create blended payment systems that provide flexibility, align funding with health system goals, and encourage multidisciplinary care.
- Expand the Practice Incentives Programme to include significantly more indicators of quality. Eventually move to a system of public reporting on the performance of individual general practices.
- Strengthen primary health quality assurance by identifying the barriers to general practice accreditation, and supporting all general practices to move towards mandatory accreditation to promote quality assurance.

3. Strengthen national safety and quality health service standards and accreditation

- Expand the scope and alignment of the National Safety and Quality Health Service Standards not only in hospitals, but also across primary health care, long-term care and mental health services.
- Build on existing work of the Australian Commission on Safety and Quality in Health Care to develop additional clinical care standards and supporting clinical indicators in priority areas, and implement strategies to improve their uptake and monitoring of compliance.
- Include accreditation outcomes in the National Health Performance Authority's public performance reporting on health care. Public reporting should be co-ordinated through the MyHospitals website to improve understanding and interpretation.
- Ensure the planned evaluation of the standards and accreditation scheme is undertaken and assesses both the impact on improvements in national co-ordination on safety and quality and on safety and quality service outcomes.
- Clarify and align requirements for private hospital licensing and accreditation purposes, to progress consistent application of the standards across government and non-government sectors.

Recommendations for improving health care quality in Australia *(cont.)*

4. Improve the quality of rural and remote health care

- Promote rural innovation through strong governance, flexible funding, local workforce innovation and enabling technology. Encourage innovation by granting high-performing health services greater autonomy through an Earned Autonomy model.
- Develop a stronger information system by investing in extending Australia's basic information set on health service needs, service use and outcomes, and build a more comprehensive set of health care quality indicators, to capture rural and remote settings and support governance and accountability.
- Build a rural generalist workforce with GPs given an expanded role in procedural and primary health care. Create broader generalist roles for nurses, pharmacists and other allied health professionals including the capacity to prescribe an appropriate range of medication. Support the creation of new roles, governed by appropriate accreditation and credentialling, training, peer review and accountability.
- Build the capacity of local health workforces by continuing to build on the growth of rural health care training facilities, including medical schools.
- Explore the feasibility of liberating Medicare funding to other health practitioners in remote areas, and consider offering financial incentives to other health practitioners to move to rural areas of need.
- Increase capacity for innovations that improve health care accessibility for people who live in remote areas and support rural physicians. This includes increasing the scope and capacity of telehealth.
- Adopt nationally consistent eligibility requirements and subsidies for patient travel. Increase payments to reflect the real costs of travel and accommodation.
- Ensure that quality-focused governance is embedded in all rural and remote health services by applying local quality measurement to clinicians who visit on an ad-hoc basis.
- Ensure a nationally consistent method of collecting patient feedback is applied to rural areas, and goes beyond hospitals to include outreach and telehealth services.

From:

OECD Reviews of Health Care Quality: Australia 2015

Raising Standards

Access the complete publication at:

https://doi.org/10.1787/9789264233836-en

Please cite this chapter as:

OECD (2015), "Assessment and recommendations", in *OECD Reviews of Health Care Quality: Australia 2015: Raising Standards*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/9789264233836-4-en

This work is published under the responsibility of the Secretary-General of the OECD. The opinions expressed and arguments employed herein do not necessarily reflect the official views of OECD member countries.

This document and any map included herein are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.

You can copy, download or print OECD content for your own use, and you can include excerpts from OECD publications, databases and multimedia products in your own documents, presentations, blogs, websites and teaching materials, provided that suitable acknowledgment of OECD as source and copyright owner is given. All requests for public or commercial use and translation rights should be submitted to rights@oecd.org. Requests for permission to photocopy portions of this material for public or commercial use shall be addressed directly to the Copyright Clearance Center (CCC) at info@copyright.com or the Centre français d'exploitation du droit de copie (CFC) at contact@cfcopies.com.

OECD