

# APPENDIX H: Investing in Reform

The following paper provides information on the financial implications of the recommendations of the Final Report. Recurrent expenditure estimates represent the full year costs for reforms that entail significant additional expenditure or generate significant savings. The estimates are indicative only and further work will be required to refine them. They are intended to give a reasonable idea of the magnitude of the changes in expenditure required to implement our reforms.<sup>232</sup> They do not take account of the improved efficiencies and more appropriate care that will be achieved in the medium to longer term, which separate modelling indicates will result in lower growth in projected expenditure on health and health care over the next two decades.

Changes in government expenditure (Commonwealth and state) have been estimated for those recommendations which we believe are greater than \$10 million per annum.

Even where costs of more than \$10 million are anticipated, some recommendations entail no additional outlays, as governments have already committed funding which can be applied to the reforms we are recommending. For example, there is already a commitment of \$1.58 billion to 'closing the gap' in Aboriginal and Torres Strait Islander people's health and life expectancy. However, even where there is an existing commitment, an amount has been included where the strategies we have proposed differ from, or add to, that existing commitment. An example is the National Health Promotion and Prevention Agency. There is already a commitment to fund a similar body, but we have included an additional \$100 million per year as we have recommended a broader range of functions and activities for such a body.

In general, we have estimated changes in government outlays based on 2008-09 dollars, and in a full year – that is, once a reform has been fully implemented. We have not attempted to estimate the incremental build up of costs over time as reforms are implemented. As it will take several years to implement many of the reforms, the incremental costs in any one year during the implementation period will be much less than the full effect across all of the reforms we propose.

Transformational capital investment to support our reform agenda is also proposed as a critical enabler of a number of key recommendations. Capital can drive change and is fundamental to the efficiencies and reorientation of the health system we are proposing. Short term capital investment will be vital to reshape how care is delivered, fill service gaps, and stimulate change and health service reform now and into the future.

The indicative range of annual costs and savings/productivity gains of the recommendations costed are summarised in Figure 1.

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232 Technical notes: Data used in this paper were mostly sourced from publicly available information.

Population projections were based on Australian Bureau of Statistics 'Series C' Population Projections Australia 2006–2101.

Figures for 30 June 2006 are final estimated resident population based on results of the 2006 Census.

Hospital costs were calculated using cost data from the National Hospital Cost Data Collection Cost Report Round 11 (2006–07) produced by the Commonwealth Department of Health and Ageing in conjunction with the States and Territories.

**Figure 1: Indicative range of recommendations with material costs or savings**

Rec	Reform	Range of costs (savings/revenue)		Comments
		\$m	\$m	
7	Supporting healthy workers			COAG funding noted
9	National Health Promotion and Prevention Agency	100	100	In addition to COAG commitment
16	Cwth responsibility funding & policy primary health care			Transfer funds from States
18	Enrolment of young families, indigenous people, the chronically ill	341	682	
19	PHC prevention, access and quality performance payments	252	800	
21	Primary health care organisations	150	150	Transformed GP Divisions
23,24	Targeted antenatal care & core contacts for child & family health			COAG funding noted
27	Nationals Access Targets and Hospitals/ED	720	1015	Hospital and ED funding
30	National activity-based hospital funding	(1330)	(570)	\$150 m implementation costs
33	National performance reporting & accountability framework	12	12	
38	Enhanced sub-acute care services/aids and equipment	460	460	Capital also required
42	Expanding provision of aged care subsidies	530	838	Note frees up hospital beddays
47	More flexible range of community aged care subsidies	296	437	Note frees up hospital beddays
52	Medical arrangements with residential aged care services	48	48	
57	Advance care planning training			\$6 million implementation costs
59	Aboriginal & Torres Strait Islander health funding			Note COAG commitment
61	National Aboriginal & Torres Strait Islander Health Authority	58	58	
64	Aboriginal & Torres Strait Islander nutrition	12	12	
65	Equivalence funding in remote and rural areas	55	143	
66	Remote & rural outreach, telehealth & advice networks	50	100	
67	Patient travel assistance	85	244	
70	Rural workforce enhancement package	27	27	
71	Communities of youth services	30	30	Core funding, capital also required
72	Early psychosis prevention and intervention services	26	26	COAG funding noted
73	Rapid mental health response team	200	200	COAG funding noted
74	Sub-acute mental health services	70	70	COAG funding noted
77	Employment support for people with mental illness	7	7	COAG funding noted
78	Mental health and dementia support for older Australians	23	23	COAG funding noted
83	Dentcare Australia	3740	3740	Funding for private dental plans
84	Dental residency program	200	200	
85	School dental expansion	100	100	
86	Oral health promotion	20	20	
	Levy to fund 'Dentcare Australia'	(4060)	(4060)	Added to \$1bn in existing direct govt funding
88.9	National health intervention & private hospital regulation	25	25	
99	Reshaping MBS	140	330	Addition to nurse & midwives funding 2009-10
100	New clinical education and training framework			COAG funding noted, capital required
101	National education and training agency			COAG funding noted
102	National professional registration			COAG funding noted
104	Increasing training places in remote & rural areas			COAG capital funding noted
105	Clinical, health services and health policy research	100	100	
109	National health innovation	8	8	
111	Australian Commission for Safety and Quality in Health Care	34	34	
		<b>2529</b>	<b>5409</b>	

Note: This Table includes the costs and savings of all costed recommendations including Dentcare Australia; hence the total cost differs to that of Table 7.2 in the main report.

These indicative estimates do not reflect any interaction between recommendations – each costing is of the proposal in isolation from the others.

We have included estimates of savings which should be realised through funding hospitals based on the efficient costs of delivery. We have not estimated in dollar terms any savings from reductions in use of hospitals that we expect to flow from our recommendations to increase the availability of care that will help people stay out of hospital, or spend less time in hospital. We do expect reductions in use of hospitals for some kinds of care, but we also expect that the capacity freed up by these changes will be taken up by providing more episodes of acute care.

Figure 2 shows estimates of the reductions in hospital patient stays arising from an increase in sub-acute services, improved access to aged care, and advance care planning.

**Figure 2: Hospital bed days available for acute care due to other reforms**

<b>Hospital bed days made available</b>	<b>'000</b>	<b>'000</b>
Increased sub-acute services	531	531
Improved timely access to aged care	277	555
Advance care planning	256	256
	<b>1064</b>	<b>1341</b>

These should enable 160,000 or more episodes of acute care for people requiring at least an overnight stay in hospital.

Several recommendations also have capital components and these are summarised in Figure 3 below; some of this capital would be funded by applying the first year or two of expected recurrent funding to capital to establish services, the initial capital costs required as part of getting programs up and running are often similar to full year operating costs. For these reasons, the capital costs of new or expanded services cannot simply be added to the proposed recurrent costs, as the latter cannot be incurred until after the initial capital costs have been met.

**Figure 3: Capital Investments**

<b>Transformation capital investment</b>		<b>\$m</b>	<b>\$m</b>
17	Comprehensive PHC Centres and Services	300	300
38	Investment in sub-acute infrastructure	900	1500
71	Communities of youth health services	30	30
84	Dental training facilities for residency program	375	750
85	School dental service expansion	125	250
97	Clinical education and training facilities across settings	100	150
97	Hospital reshaping	1250	2500
123	ehealth	1185	1865
		<b>4265</b>	<b>7385</b>

## RECOMMENDATION 7

We support the delivery of wellness and health promotion programs by employers and private health insurers. Any existing regulatory barriers to increasing the uptake of such programs should be reviewed.

## RECOMMENDATION 9

We recommend the establishment of an independent national health promotion and prevention agency. This agency would be responsible for national leadership on the Healthy Australia 2020 goals, as well as building the evidence base, capacity and infrastructure that is required so that prevention becomes the platform of healthy communities and is integrated into all aspects of our health care system.

We recommend that the national health promotion and prevention agency would also collate and disseminate information about the efficacy and cost effectiveness of health promotion including primary, secondary and tertiary prevention interventions and relevant population and public health activities.

### **Additional annual cost**

\$100 million

### Costing Assumptions

COAG has made a commitment to funding of \$797.77 million through the National Partnership Agreement on Preventive Health<sup>233</sup> and establishing a national preventative health agency tasked with responsibility for providing evidence-based policy advice, overseeing a Commonwealth funded social marketing campaign to extend and complement the Australian Better Health initiative campaign, with states and territories funded to facilitate delivery of healthy living programs in workplaces.

To fulfil the functions we have proposed, the additional cost of national health promotion and prevention is \$100 million including \$30 million for core functions of collating and disseminating information, reporting and publishing wellness footprints, development of evidence based programs for secondary and tertiary prevention, \$30 million for research, surveillance and promotion of prevention activities across the health system and \$40 million for the Healthy Australia Goals development and social marketing. Although COAG has made a commitment to fund the National Health Promotion and Prevention Agency through the National Partnership Agreement on Preventive Health, the level of funding for the Agency is unclear.

233 Council of Australian Governments National Partnership on Preventive Health (2009), At: [http://coag.gov.au/intergov\\_agreements/federal\\_financial\\_relations/docs/national\\_partnership/national\\_partnership\\_on\\_preventive\\_health.rtf](http://coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_preventive_health.rtf)

## RECOMMENDATION 16

We recommend that, to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding.

<b>Annual cost</b>	No net costs
Costing Assumptions	Funds transferred from state to Commonwealth for primary health care.  2006–07 community health care and other non-institutional funding not elsewhere classified was \$4,105 million, \$3,637 million was funded by the states <sup>234</sup> .

## RECOMMENDATION 17

We recommend that, in its expanded role, the Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres and Services. We suggest this could be achieved through a range of mechanisms including initial fixed establishment grants on a competitive and targeted basis. By 2015 we should have a comprehensive primary health care system that is underpinned by a national policy and funding framework with services evolving in parallel.

<b>Capital cost</b>	\$300 million – establishment grants
Costing Assumptions	25 per cent population to have access to Comprehensive Primary Health Centres (CPHC) by 2020 (currently only about a million people have access to comprehensive primary care services).  On average a centre or service will include 15 full work equivalent GPs able to service a population of 17,190 <sup>235</sup> .  On average a one-off incentive of \$1 million to facilitate the establishment of CPHCs.  For comparison, the level of funding for GP super clinics ranged from \$1m to \$12.5m with most between \$2.5m and \$5m.  A previous GP practice amalgamation program in the early 2000's offered payments of \$7500 per FTE practitioner in each eligible amalgamating practice for up to three FTE GPs, plus \$15,000 per eligible practice with a total ceiling payment \$120,000. This program was oversubscribed. However it did not require any non GP involvement and the nature of the amalgamation was much less tightly defined than the creation of the comprehensive centres.

234 Australian Institute of Health and Welfare (2008, )Health expenditure Australia 2006-07, At: <http://www.aihw.gov.au/publications/index.cfm/title/10659>

235 Extrapolated from Department of Health & Ageing (2009), Number of General Practitioners, At: [http://www.health.gov.au/internet/main/publishing.nsf/Content/4F4DB38797665644CA256FFE000C3C7F/\\$File/Table%201.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/4F4DB38797665644CA256FFE000C3C7F/$File/Table%201.pdf)

## RECOMMENDATION 18

We recommend that young families, Aboriginal and Torres Islander people and people with chronic and complex conditions (including people with a disability or a long-term mental illness) have the option of enrolling with a single primary health care service to strengthen the continuity, co-ordination and range of multidisciplinary care available to meet their health needs and deliver optimal outcomes. This would be the enrolled family or patient's principal "health care home". To support this, we propose that: there will be grant funding to support multidisciplinary services and care coordination for that service tied to levels of enrolment of young families and people with chronic and complex conditions; there will be payments to reward good performance in outcomes including quality and timeliness of care for the enrolled population and over the longer term, payments will be developed that bundle the cost of packages of primary health care over a course of care or period of time, supplementing fee-based payments for episodic care.

**Annual cost** \$341–\$682 million depending on the level of enrolment. As enrolment is restricted by both patients' willingness to enrol and services' willingness to participate in the program, \$341m or 50 per cent enrolment is a more likely figure. \$682m implies 100 per cent enrolment.

**Costing Assumptions** That the number of people eligible to enrol is 32 per cent of the population and includes:

Aboriginal & Torres Strait Islander people <sup>236</sup>	517,000
Children 0–5 years <sup>237</sup>	1,640,000
People with chronic and complex conditions <sup>238</sup>	3,272,700
People with a disability <sup>239</sup>	640,000
People with a mental health problem <sup>240</sup>	750,000
<b>TOTAL</b>	<b>6,819,700</b>

It is important to note that, as the number of people who have chronic conditions do not all face complex care needs, the estimated number eligible to enrol includes all those with coronary heart disease, lung and colorectal cancer, 80 per cent with Chronic Obstructive Pulmonary Disease and chronic kidney disease, 50 per cent with depression or osteoporosis, 30 per cent with diabetes or arthritis and 25 per cent of those with asthma. Similarly, for people with a disability we have included half of those with profound or a severe core activity limitation and half of those people with a mental health problem (excluding depression). These estimates include allowance for overlap and co-morbidities.

At around 32 per cent of the population eligible to enrol, if payments were made of \$100 per enrollee, then an average GP would receive enrolment payments of around \$32,500, and an average practice (4.5 practitioners) would receive payments of around \$146,000. This would enable an average size practice to employ 1.5 additional staff.

The cost of payments to reward good performance in outcomes including quality and timeliness of care for the enrolled population has been included in Recommendation 19.

The additional cost of bundling payments for enrolled individuals over a course of care has been assumed to be nil.

236 Australian Institute of Health and Welfare (2008), The health and welfare of Australia's Aboriginal & Torres Strait Islander peoples

237 Australian Bureau of Statistics (2008), Estimated resident population, June 2008

238 Derived from Australian Institute of Health and Welfare, Incidence and prevalence of chronic disease, At: [http://www.aihw.gov.au/cdarf/data\\_pages/incidence\\_prevalence/index.cfm](http://www.aihw.gov.au/cdarf/data_pages/incidence_prevalence/index.cfm)

239 Australian Bureau of Statistics, People with a disability, At: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features12003?OpenDocument>

240 <http://www.abs.gov.au/ausstats/abs@.nsf/ProductsbyReleaseDate/2D997BB70468E5ADCA2571D900201FB3?OpenDocument>

## RECOMMENDATION 19

We recommend embedding a strong focus on quality and health outcomes across all primary health care services. This requires the development of sound patient outcomes data for primary health care. We also want to see the development of performance payments for prevention, timeliness and quality care.

**Annual cost** \$252–\$800 million

**Costing Assumptions** The total level of incentive payment will be dependent on the outcome targets which are set, and may to some degree be offset by reductions in ongoing payments such as redirection of indexation and growth.

As an indicator of current outcome payments, the PIP/SIP arrangements which provide incentives for information management, after hours care, practice nurses, quality prescribing, teaching, asthma management, diabetes management, cervical screening and several other factors expends around \$309 m per annum<sup>241</sup> (about 7 per cent of MBS benefits paid in respect of general practice services).

If the same proportion of the costs of currently state funded primary health care services were added to the system as outcome incentive payments, this would add \$252m to costs.

If the current level of incentives for general practice was to double to 14 per cent to cover a much wider range of conditions and services, and incentive payments for currently state funded services were to be implemented at 7 per cent of current funding levels, the total additional cost would be \$561m.

If the current level of incentives for general practice was to double to 14 per cent to cover a much wider range of conditions and services, and incentive payments for currently state funded services were to be implemented also at 14 per cent of current funding levels, the total additional cost would be \$800m.

## RECOMMENDATION 21

Service coordination and population health planning priorities should be enhanced at the local level through the establishment of Primary Health Care Organisations, evolving from or replacing the existing Divisions of General Practice. These organisations will need to have appropriate governance to reflect the diversity of clinicians and services forming comprehensive primary health care; be of an appropriate size to provide efficient and effective coordination (say approx 250,000 to 500,000 population depending on health need, geography and natural catchment) meet required criteria and goals to receive ongoing Commonwealth funding support.

**Annual cost** \$150 million

**Costing Assumptions** Divisions received \$157 million in 2004–05<sup>242</sup>

To expand the Divisions scope to cover all of primary health care would more than double their potential membership and range of issues. As an indicative cost therefore, \$150m per year may be a start point.

241 DoHA 2008–09 Budget Outcome 5 Program 5.4 Practice Incentives Program (PIP)

242 [http://www.mja.com.au/public/issues/187\\_02\\_160707/sco10472\\_fm.html](http://www.mja.com.au/public/issues/187_02_160707/sco10472_fm.html)

## RECOMMENDATION 23

We recommend beginning the strategy for nurturing a healthy start to life before conception. Universal services would focus on effective health promotion to encourage good nutrition and healthy lifestyles, and on sexual and reproductive health services for young people. Targeted services would include ways to help teenage girls at risk of pregnancy. In the antenatal period, in addition to good universal primary health care, we recommend targeted care for women with special needs or at risk, such as home visits for very young, first-time mothers.

## RECOMMENDATION 24

We recommend that universal child and family health services provide a schedule of core contacts to allow for engagement with parents, advice and support, and periodic health monitoring (with contacts weighted towards the first three years of life). The initial contact would be universally offered as a home visit within the first two weeks following the birth. The schedule would include the core services of monitoring of child health, development and wellbeing; early identification of family risk and need; responding to identified needs; health promotion and disease prevention (for example, support for breastfeeding); and support for parenting. Where the universal child and family health services identify a health or developmental issue or support need, the service will provide or identify a pathway for targeted care, such as an enhanced schedule of contacts and referral to allied health and specialist services. Where a child requires more intensive care for a disability or developmental concerns, a care coordinator, associated with a primary health care service, would be available to coordinate the range of services these families often need.

### **Annual cost**

The net additional cost of these recommendations could be nil as COAG has made a commitment to fund the following outcome:

*“help assure Australian children of a healthy start to life, including through promoting positive parenting and supportive communities, and with an emphasis on the new-born”*

States will receive, through the National Partnership Agreement on Preventive Health, \$326 million over 6 years from 2009-10, half by way of facilitation payments and the balance in the final years for the Healthy Children Program.<sup>243</sup>

### Costing Assumptions

It has not been possible to cost these recommendations as data is not available on the current level of service provision nor on current costs or on the target population. Services are predominantly state managed and funds are included in community health funding of \$3,637 million expended by states in 2006–07.

243 [http://coag.gov.au/intergov\\_agreements/federal\\_financial\\_relations/docs/national\\_partnership/national\\_partnership\\_on\\_preventive\\_health.rtf](http://coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_preventive_health.rtf)

## RECOMMENDATION 27

We recommend development and adoption of National Access Targets for timeliness of care. For example: a national access target for people requiring an acute mental health intervention (measured in hours); a national access target for patients requiring urgent primary health care (measured in hours or days); national access targets for people attending ED (measured in minutes to hours); a national access target for patients requiring coronary artery surgery or cancer treatment (measured in weeks/days); and a national access target for patients requiring other planned surgery or procedures (measured in months). These National Access Targets should be developed incorporating clinical, economic and community perspectives through vehicles like citizen juries and may evolve into National Access Guarantees subject to ensuring there is no distortion in allocation of health resources.

**Annual cost:** up to \$425m pa for elective surgery NATs (including \$150m to continue current COAG funding beyond 2010–11)  
\$295–590m pa for emergency access NATs

### Costing assumptions **Elective Surgery NATs**

Preliminary analysis suggests that the additional funding already available through the Elective Surgery Waiting List Reduction Plan could, if extended beyond 2010–11, be sufficient to address excess waiting times.

This assumes:

- existing demand trends continue;
- total outlays on public hospitals continue to grow at recent historical rates;
- addressing bottlenecks allows long wait patients to be treated faster while delaying the treatment of others who nevertheless are treated within targeted timeframes.

However, additional demand created by removal of excess waiting times is estimated to increase demand by up to 50,000 cases. This could cost up to \$275m per annum although this would be reduced if existing cases were delayed within the target.

### **Emergency Access**

The proposed national access target requires all hospitals with a major Emergency Department to maintain an occupancy rate no higher than 85 per cent. While the national average occupancy rate in 2006–07 was 85 per cent, this varied between states (in the range of 76 per cent – 97 per cent with Northern Territory as an outlier at 118 per cent) and could vary more at the individual hospital level.

Assuming that the average reduction in occupancy rate required is 5 percentage points, the number of extra beds required would be 1,776 or 3,552 for a 10 percentage point reduction in occupancy. As this is a buffer of empty beds to be maintained, their average cost, unoccupied, would be low relative to occupied beds.

Assuming that the average cost is \$455 per unoccupied bed-day then the cost of maintaining these beds is about:

\$295m per annum for an average 5 percentage point reduction in occupancy

\$590m per annum for an average 10 percentage point reduction in occupancy.

Some or all of the funding could be made available in the form of bonus payments linked to achievement of the 85 per cent occupancy target at specific hospitals.

## RECOMMENDATION 30

We recommend the use of activity-based funding for both public and private hospitals using casemix classifications (including the cost of capital). This approach should be used for inpatient and outpatient treatment. Emergency department services should be funded through a combination of fixed grants (to fund availability) and activity-based funding. For hospitals with a major emergency department service the costs of maintaining bed availability to admit people promptly should be recognised in the funding arrangements.

<b>Annual savings</b>	\$400 million – \$900 million for acute public inpatient services. \$170 million – \$430 million for non-admitted public patient services (savings would be progressively available as implementation progressed)
<b>Offsetting costs</b>	\$150m over 4 years to develop technical infrastructure.
<b>Costing assumptions</b>	The \$400m saving estimate for acute inpatient services assumes that the higher average cost per episode in some states are brought down to the average cost. \$900 million saving assumes all states can match the level of efficiency currently achieved by the most efficient state.

The savings estimate for non-admitted patient services is based on the estimate that non-admitted patient services are 30 per cent of total public hospital costs.

The implementation cost estimate is sourced from COAG papers.<sup>244</sup>

Savings estimates are based on 2006-07 activity levels and costs.<sup>245</sup>

### Average cost including depreciation

Public Sector by Jurisdiction	Number of weighted separations	Average cost per weighted separation	Average cost per disability adjusted separation
		2006-07	2006-07 <sup>246</sup>
NSW	1,427,254	\$3,754	\$3,815
Vic	1,222,040	\$3,514	\$3,721
Qld	751,072	\$3,694	\$3,711
SA	366,929	\$3,575	\$3,747
WA	419,537	\$4,355	\$3,688
Tas	98,948	\$4,209	\$3,530
NT	62,327	\$4,680	\$3,863
ACT	73,703	\$4,285	\$4,053
<b>National</b>	<b>4,422,191</b>	<b>\$3,751</b>	<b>\$3,757</b>

244 [http://www.coag.gov.au/intergov\\_agreements/federal\\_financial\\_relations/docs/national\\_partnership/national\\_partnership\\_on\\_hospital\\_and\\_health\\_workforce\\_reform.pdf](http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_hospital_and_health_workforce_reform.pdf)

245 [http://www.health.gov.au/internet/main/publishing.nsf/Content/5F8B6BE822DC75B3CA25748300164037/\\$File/R11CostReport\\_Final.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/5F8B6BE822DC75B3CA25748300164037/$File/R11CostReport_Final.pdf)

246 Based on Commonwealth Grants Commission 2008 updated data

### RECOMMENDATION 33

To improve accountability, we recommend that public and private hospitals be required to report publicly on performance against a national set of indicators which measure access, efficiency and quality of care provided.

**Annual Cost** 12 million

**Costing Assumptions** The proposed national function estimated funding requirement is based on the current level of Australian government funding of current national health bodies together with their reported operating expenses in 2007–08.

Australian Institute of Health and Welfare currently exists and its funding could be increased to reflect an expanded function of national performance reporting.

### RECOMMENDATION 38

We recommend that clear targets to increase provision of sub-acute services be introduced by June 2010. These targets should cover both inpatient and community-based services and should link the demand for sub-acute services to the expected flow of patients from acute services and other settings. Incentive funding under the National Partnership Payments could be used to drive this expansion in sub-acute services.

### RECOMMENDATION 41

We recognise the vital role of equipment, aids and other devices, in helping people to improve health functioning and to live as independently as possible in the community. We recommend affordable access to should equipment should be considered under reforms to integrated safety net arrangements.

**Annual Cost** \$460 million operating costs of expanded sub-acute inpatient and ambulatory services at the same level as Victoria and increased provision of aids and appliances

**Costing Assumptions** COAG has made a commitment to expand service provision levels by 5 per cent annually from 2009–10 to 2012–13<sup>247</sup> with additional Commonwealth funding of \$500 million in 2008-09. Expanding sub-acute service provision by 5 per cent annually until 2012–13 will increase the national average beds per 1,000 older people (70 years and over) from 3 beds<sup>248</sup> to 3.6 beds, the number of beds will increase by 1560 to 8,800.

The proposed bed numbers does not include allocated Transition Care places – these are seen as needed in addition to rehabilitation and Geriatric Evaluation and Management (GEM) beds<sup>249</sup>.

247 [http://www.coag.gov.au/intergov\\_agreements/federal\\_financial\\_relations/docs/national\\_partnership/national\\_partnership\\_on\\_hospital\\_and\\_health\\_workforce\\_reform.rtf](http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_hospital_and_health_workforce_reform.rtf)

248 Figure 5.3 National Health and Hospitals Reform Commission Interim Report December 2008

249 National Evaluation of the Transition Care Program

The Australasian Faculty of Rehabilitation Medicine has conservatively estimated that the number of rehabilitation beds alone needs to increase by 43 per cent equivalent to an extra 1 870 rehabilitation beds (from 4,348 beds to 6,218) and that overall the number of rehabilitation and GEM beds required is 45 beds per 100,000 people being 9,500 beds.<sup>250</sup>

If the number of rehabilitation and GEM beds per 1,000 older people (70 years and over) is increased nationally to the same level as Victoria then the number of beds will increase by a further 1 455 to 10,255 requiring further funding of \$276 million per year.

The annual cost has been calculated at the 2008/09 Victorian rehabilitation bed day rate of \$520<sup>251</sup> indexed by 3 per cent to reflect depreciation. Compensable revenue such as workers compensation insurance and motor vehicle third party insurance has not been offset against the cost as it is unlikely to increase with additional sub-acute beds. The annual cost does not include Transition Care expenditure.

The annual cost also includes a 10 per cent increase in direct Commonwealth outlays for aids and appliances which was \$298 million in 2006–07 (or \$29.8 million).

The annual cost of providing sub-acute ambulatory care to the level of Victoria would be \$307 million based on funding at Victoria's 2007-08 level of \$169 per person aged 70 years and over. If we assume that the existing level of ambulatory provision in states and territories other than Victoria is half the Victorian level, then the additional cost of bringing all states and territories up to the Victorian level would be \$154 million.

In total, the costs are \$276 million for sub-acute inpatient services, \$29.8 million for aids and equipment and \$154 million for sub-acute ambulatory services, equalling \$460 million.

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250 Australasian Faculty of Rehabilitation Medicine (2008) Submission 21 to the National Health and Hospitals Reform Commission  
251 <http://www.health.vic.gov.au/pfg/pfg0809/pfg0809.pdf>

## RECOMMENDATION 42

We recommend that government subsidies for aged care should be more directly linked to people rather than places. As a better reflection of population need, we recommend the planning ratio transition from the current basis of places per 1000 people aged 70 or over to care recipients per 1000 people aged 85 or over.

### Annual cost

	<b>additional places resulting from new 85+ ratio of 620 places/1000</b>	<b>additional cost resulting from new 85+ ratio of 620 places/1000</b>
June 2011	16368	\$530,171,127
June 2012	20450	\$662,398,152
June 2013	24453	\$792,073,110
June 2014	25831	\$836,684,503
June 2015	26711	\$865,195,420
June 2016	25892	\$838,683,004
June 2017	18705	\$605,891,725
June 2018	12608	\$408,383,382
June 2019	6940	\$224,788,818
June 2020	1468	\$47,546,484

Costing assumptions That the ratio of places which is targeted to be 113 places per 1000 people aged 70 and over by 2011 will change to 620 care recipients per 1000 people aged 85 or over<sup>252</sup>.

The annual cost is additional to the cost of maintaining the ratio at 113 places per 1000 people aged 70 or over.

The mix of residential and community care subsidies will remain as is, that is

- Residential high care 39 per cent (target of 44 places out of 113)
- Residential low care 39 per cent (target of 44 places out of 113)
- Community aged care 19 per cent (target 21 packages out of 113)
- EACH packages 3 per cent (target 4 packages out of 113)<sup>253</sup>.

The average cost of residential care is \$37,900.

The average cost of community & EACH care is \$13,000.

252 [http://www.ausstats.abs.gov.au/ausstats/abs@archive.nsf/0/E4B1AAE2BF6356A1CA2574B90016BCC3/\\$File/32220c9.xls](http://www.ausstats.abs.gov.au/ausstats/abs@archive.nsf/0/E4B1AAE2BF6356A1CA2574B90016BCC3/$File/32220c9.xls)

253 <http://www.aihw.gov.au/publications/age/raca06-07/raca06-07.pdf>

The total number of aged care places in June 2007 equated to 620 places per 1000 people aged 85 and over.

Changing the target of provision of aged care subsidies to 620 care recipients per 1000 people aged 85 or over requires an increase of 6 per cent or \$580 million per annum on average over 10 years above the funding required to maintain the 2011 target of 113 places per 1000 people aged 70 or more years.

There will be a resulting reduction in hospital stays with savings of 277,000 to 547,000 bed days<sup>254</sup>.

## RECOMMENDATION 47

We recommend that there be a more flexible range of care subsidies for people receiving community care packages, determined in a way that is compatible with care subsidies for residential care.

**Annual cost** \$296m – \$437 million

**Costing Assumptions** These indicative costs use a baseline of 46,300 community places, of which 2000 are Extended Aged Care at Home – Dementia (EACH-D) places and 4300 are Extended Aged Care at Home (EACH) places, with the remaining 40,000 being Community Aged Care Packages (CACP). This approximates the allocation of community care places in mid-2008.

The Aged Care Funding Instrument used in residential aged care provides many different levels of funding according to basic care needs, complex health care needs and challenging behaviour. Lacking any data as to the likely distribution of these characteristics for people receiving community care, we have taken a simpler approach.

For both the high and the low range estimates we have assumed that the baseline numbers of EACH and EACH-D recipients remain unchanged, and that the levels of care subsidy would be the same as currently apply, at \$42,398 pa and \$46,760 pa respectively.

For the high range estimate, we assumed that the lowest level of subsidy would be the same as for a CACP now – \$12,683 pa, and the two highest levels would be the same as currently apply for EACH and EACH-D packages, \$42,398 pa and \$46,760 pa respectively. Five new intermediate levels of community care would have increasing levels of subsidy evenly spread from \$17,636 pa to \$37,446 pa.

For the high range estimate, we assumed that 40,000 recipients of community care other than EACH and EACH-D would decline linearly from 8357 receiving the lowest level of subsidy to 5000 receiving the highest level below an EACH package.

For the low range estimate, we have assumed that the lowest level of subsidy would be less than for a CACP now, or \$10,000 pa, with more people on the lower levels of care subsidy, and many fewer on the higher of the new levels.

Our assumption of a diminishing number of people in the higher levels takes into account the level of informal care that people generally require to remain at home. As people's dependency levels increase, fewer have carers who are able to support them at home even with higher levels of subsidised care. In the lower cost scenario, our assumption that the lowest level of care subsidy would be lower than a current CACP, takes into account that some people receive less than average levels of care under current CACPs and some receive more.

Baseline				high range estimate			low range estimate		
	recipients	subsidy (\$pa) \$m		recipients	subsidy (\$pa) \$m		recipients	subsidy (\$pa) \$m	
CACP	40,000	12,683	507	8,357	12,683	106	12,222	10,000	122
				7,681	17,636	135	7,996	15,400	123
				7,005	22,588	158	5,916	20,799	123
				6,329	27,541	174	4,953	26,199	130
				5,652	32,493	184	4,538	31,599	143
EACH	4,300	42,398	182	4,300	42,398	182	4,300	42,398	182
				EACH-D	2,000	46,760	94	2,000	46,760
		46,300	783	46,300	239,545	1,220	46,301	230,155	1,079
				Additional expenditure		437	Additional expenditure		296

## RECOMMENDATION 52

We recommend that funding be provided for use by residential aged care providers to make arrangements with primary health care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes.

### Annual cost

\$48 million being \$172 million cost of contracting GPs less offset of reduction in MBS rebates of \$124 million

### Costing Assumptions

As at 30 June 2007 there were 153,426 permanent residents in 2872 mainstream residential aged care services in Australia. On average there were 58 places per service.<sup>255</sup>

71 per cent of residents are female and 54 per cent of residents are aged 85 years and over. On average this age group of women visit their GP over 10 times per year but men visit less frequently.<sup>256</sup>

That the annual cost of contracting a GP (or other health professionals with appropriate competencies) to provide on average 30 minutes consultation per permanent resident per month is \$60,000 for an average sized aged care home with just under 60 residents (based upon the NSW sessional rate for GPs<sup>257</sup>, with an average of 2 sessions of 3 hours per week per aged care home).

There may be some offsetting reductions in MBS rebates if there is no increase in GP workforce and overall GP activity remains constant (a GP's available practice consulting time would be reduced by about 6 hours per week whilst providing residential aged care services). The offsetting reduction in MBS

255 <http://www.aihw.gov.au/publications/age/raca06-07/raca06-07.pdf>

256 <http://www.aihw.gov.au/publications/age/oag04/oag04-c00.pdf>

257 [http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007\\_032.pdf](http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_032.pdf)

rebates has been estimated at \$124 million based on a reduction of 24 Item 23 Level B<sup>258</sup> consults per week per participating GP. There is probably little offsetting reduction in MBS diagnostic rebates as the level of pathology and radiology tests would remain at a similar level.

## RECOMMENDATION 57

We recommend that advance care planning be funded and implemented nationally commencing with all residential aged care services, and then being extended to other relevant groups in the population. This will require a national approach to education and training of health professionals including greater awareness and education among health professionals of the common law right of people to make decisions on their medical treatment, and their right to decline treatment. We note that, in some states and territories, this is complemented by supporting legislation that relates more specifically to end of life and advance care planning decisions.

**Annual Cost** Ongoing costs will be minimal but there will be implementation costs of \$6 million over 4 years for training staff in residential aged care services and other relevant groups.

**Annual Savings** As highlighted in the Interim Report, it is envisaged that there will be a resulting substantial reduction in hospital admissions and length of stay with savings of 256,000 bed days.

**Costing Assumptions** Implementation costs are based on the cost of the oral and dental plan for nursing homes announced March 2009.

In 2006–07, 44,271 permanent aged care residents died.

The reduction in hospital admissions and length of stay is based on research undertaken at Austin Health where residents in aged care facilities who had been introduced to the Respecting Patient Choices program had an 18 per cent chance of hospital admission with an average length of stay of 6.9 days and residents in aged care facilities who had **not** been introduced to the respecting Patient Choices program had a 46 per cent chance of hospital admission with an average length of stay of 15.3 days prior to dying<sup>259</sup>.

## RECOMMENDATION 59

We recommend an investment strategy for Aboriginal and Torres Strait Islander people's health that is proportionate to health need, the cost of service delivery, and the achievement of desired outcomes. This requires a substantial increase on current expenditure.

**Additional Cost** The net additional cost of this is proposed to be zero, as COAG has agreed to funding of \$1.58 billion over the four years 2009-10 to 2012-13. Accordingly the Commission's recommendation does not entail additional expenditure above what would be required by the existing commitment apart from the additional cost for the operations of the National Aboriginal and Torres Strait Islander Health Authority (Recommendation 61) and additional funding for good nutrition and a healthy diet (Recommendation 64). Any additional costs arising from building the organisational capacity of Community Controlled Health Services (Recommendation 60) would be funded from the existing commitment.

258 <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q1=NotelD&q=A5>

259 Austin Health (2008) Submission 534 to NHHRC

## RECOMMENDATION 61

Acknowledging that significant additional funding in Aboriginal and Torres Strait Islander health care will be required to close the gap, we recommend that a dedicated, expert commissioning group be established to lead this investment. This could be achieved by the establishment of a National Aboriginal and Torres Strait Islander Health Authority within the Health portfolio to commission and broker services specifically for Aboriginal and Torres Strait Islander people and their families as a mechanism to focus on health outcomes and ensure high quality and timely access to culturally appropriate care.

**Annual cost** \$58 million

**Costing Assumptions** The cost is based on the 2007–08 costs of administering the DVA health services for repat card holders of \$ 96.9 million offset by the funding in 2008–09 of OATSI<sup>260</sup> program management of \$38.5 million (net cost of \$58.4 million). As at June 2008 there were 294,977 repat card holders, the cost of DVA arrangements for delivery of health and other care services during 2007–08 was \$74.9 million plus allocated overheads of \$21.9 million (totalling \$96.9 million). DVA administers about \$4.7 billion in health services expenditure. Although the Aboriginal and Torres Strait Islander population is greater than the number of repat card holders, a similar sized organisation to DVA is envisaged given the different nature of tasks.

## RECOMMENDATION 64

We support the delivery of wellness an Good nutrition and a healthy diet are key elements of a healthy start to life. But many Aboriginal and Torres Strait Islander people living in remote areas have limited access to affordable healthy foods. We recommend an integrated package to improve the affordability of fresh food – particularly fruit and vegetables – in these targeted remote communities. This package would include subsidies to bring the price of fresh food in line with large urban and regional centres, investment in nutrition education and community projects, and food and nutrient supplementation for schoolchildren, infants, and pregnant and breastfeeding women. The strategy would be developed in consultation with these Aboriginal and Torres Strait Islander communities, building on some of the successful work already underway. There would be an evaluation to assess the benefits of extending the program to other communities, focusing on the changes to eating habits and improvements to health. d health promotion programs by employers and private health insurers. Any existing regulatory barriers to increasing the uptake of such programs should be reviewed.

**Annual cost** \$12 million

**Costing Assumptions** A notional amount has been included as information is not available to accurately cost this proposal.

260 [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009\\_Health\\_PBS/\\$File/Outcome%208.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009_Health_PBS/$File/Outcome%208.pdf)

## RECOMMENDATION 65

Flexible funding arrangements are required to reconfigure health service delivery to achieve the best outcomes for the community. To facilitate locally designed and flexible models of care in remote and small rural communities, we recommend: funding equivalent to national average medical benefits and primary health care service funding, appropriately adjusted for remoteness and health status, be made available for local service provision where populations are otherwise under-served; and expansion of the multi-purpose service model to towns with catchment populations of approximately 12,000.

<b>Annual cost</b>	\$55 million – \$143 million depending on whether this reform applies to rural as well as remote-rural and remote populations and GP-only primary health care										
Costing Assumptions	<p>The annual cost of funding equivalent to national average medical benefits has been based on increasing the level of funding for people in rural, remote-rural and remote communities to the national average benefit per person Australia wide of all Medicare rebates processed for GP services 2007- 08 only.</p> <p>The cost excludes funding for the Aboriginal and Torres Strait Islander population as their health needs will be funded as per Recommendation 59.</p> <p>The Rural Remote Metropolitan Area (RRMA) classification system has been used as amended by the Primary Health Care Research and Information Service.<sup>261</sup></p> <p>Remote Divisions of General Practice included NSW Outback, Kimberley, Goldfields Esperance, Pilbara and Central Australia (now part of NT SBO).</p> <p>Rural-remote Divisions of General Practice included Murrumbidgee, East Gippsland, Mallee, Central Queensland Rural, Mackay, Rhealth, North &amp; West Qld Primary Health Care, Far North Queensland Rural, Eyre Peninsula, Flinders and Far North, Great Southern GP Network, Mid West and Wheatbelt GP Network.</p> <p>Rural Divisions of General Practice included Shoalhaven, Hastings Macleay, Mid North Coast, Northern Rivers, New England, Riverina, NSW Central West, Dubbo Plains, Barwon, North West Slopes (NSW), North East Victorian, Central West Gippsland, Otway, Ballarat &amp; District, Central Victoria, Goulburn Valley, Albury Wodonga Regional, West Victoria, Murray Plains, GP Connections, General Practice Cairns, Sunshine Coast, Capricornia, Wide Bay, Barossa, Yorke Peninsula, Mid North, Riverland, Limestone Coast, Murray Mallee, GP Down South, Greater Bunbury, General Practice North (Tas) and General Practice North West</p> <p>The average \$ Benefit per person all Medicare rebates processed for GP services 2007–08<sup>262</sup> were</p> <table style="margin-left: auto; margin-right: 0;"> <thead> <tr> <th></th> <th style="text-align: right;"><b>\$ Benefit per person</b></th> </tr> </thead> <tbody> <tr> <td><b>Remote</b></td> <td style="text-align: right;">\$120</td> </tr> <tr> <td><b>Rural-remote</b></td> <td style="text-align: right;">\$178</td> </tr> <tr> <td><b>Rural</b></td> <td style="text-align: right;">\$200</td> </tr> <tr> <td><b>Total Australia</b></td> <td style="text-align: right;">\$218</td> </tr> </tbody> </table>		<b>\$ Benefit per person</b>	<b>Remote</b>	\$120	<b>Rural-remote</b>	\$178	<b>Rural</b>	\$200	<b>Total Australia</b>	\$218
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<b>Rural</b>	\$200										
<b>Total Australia</b>	\$218										

261 <http://www.phcris.org.au/fastfacts/fact.php?id=4801>

262 Extrapolated from Div GP All Medicare by MBS category

Due to data constraints it has not been possible to determine the level of other state and Commonwealth primary health care expenditure that applies to rural and remote communities. It has not been possible to determine which communities receive total primary care funding at a level similar to metropolitan areas and which are otherwise underserved. The Commonwealth alone has more than 60 programs<sup>263</sup> funding rural health initiatives, including the following:

	\$m
<b>PIP Rural Loading</b> <sup>264</sup>	27
<b>PIP Rural Practice nurse incentive</b> <sup>265</sup>	23
<b>More Allied Health Services</b> <sup>266</sup>	14.9
<b>Royal Flying Doctor Service</b> <sup>267</sup>	70
<b>Regional Health Services</b> <sup>268</sup>	28.3
<b>Total</b>	<b>163.2</b>

Costs have not been indexed to reflect the effect of geographic location as it has proven difficult to estimate the total effect of geographic location. The major factors explaining variability in costs between practices are identified below:

### Effect of geographic location on cost categories<sup>269</sup>

Resource category	Major effect of geographic location
Wages and staff costs	Reception staff salary levels do not vary greatly across Australia. Higher levels are recorded in Sydney and Melbourne.
Occupancy costs	Location of practice in a hospital or medical precinct is the greatest determinant of rent variation. In the same location, rents are highest in Sydney and Melbourne with lower rents in Hobart. Rurality affects rent favourably but availability of suitable accommodation may negate this.
Office expenses	No great variation between states but can increase with rurality.
Professional costs	Higher cost of travel for CME in some areas but this is often offset by subsidies in remote areas.
Motor vehicle expenses	Higher cost of fuel in some states and areas. Higher cost of insurance in Sydney and Melbourne. Difficult to estimate the total effect.
Professional indemnity	Clear state differentials.
Working capital expenses	No substantial differences across states or locations. Recent Regional Prices Indices prepared for Western Australia <sup>270</sup> and Queensland have highlighted the significant impact that mining can have on remote communities particularly with the costs of housing. The least expensive regions compared with Brisbane were found in regional Queensland. <sup>271</sup> The remote areas of Pilbara, Kimberley and Goldfields-Esperance have significantly higher commodity prices greater than Perth.

263 [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009\\_Health\\_PBS/\\$File/Outcome%206.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009_Health_PBS/$File/Outcome%206.pdf)

264 DoHA 2007-08 expenditure unpublished data

265 DoHA 2007-08 expenditure unpublished data

266 DoHA 2003-04 Budget as forecast 2000-01

267 RFDS 2007-08 Finance Statements

268 DoHA 2003-04 Budget as forecast 2000-01

269 PricewaterhouseCoopers 2000 Medicare Schedule Review

270 <http://www.dlgrd.wa.gov.au/Publications/Docs/RegionalPriceIndex2007.pdf>

271 <http://www.oesr.qld.gov.au/queensland-by-theme/economic-performance/prices/regular-publications/index-retail-prices-reg-centres/index-retail-prices-reg-centres-200605.pdf>

## RECOMMENDATION 66

Care for people in remote and rural locations necessarily involves bringing care to the person or the person to the care. To achieve this we recommend: networks of primary health care services, including Aboriginal and Torres Strait Islander Community Controlled Services, within naturally defined regions; expansion of specialist outreach services – for example, medical specialists, midwives, allied health, pharmacy and dental/oral health services; telehealth services including practitioner-to-practitioner consultations, practitioner-to-specialist consultations, teleradiology and other specialties and services; referral and advice networks for remote and rural practitioners that support and improve the quality of care, such as maternity care, chronic and complex disease care planning and review, chronic wound management, and palliative care; and ‘on-call’ 24-hour telephone and internet consultations and advice, and retrieval services for urgent consultations staffed by remote medical practitioners. Further, we recommend that funding mechanisms be developed to support all these elements.

**Additional cost** \$50–\$100 million

**Costing assumptions** We have not had the opportunity to estimate the cost of the many different initiatives contained within this recommendation. To ensure that some allowance is made for the cost of these reforms we have allocated a notional range of \$50–\$100 million in a full year.

## RECOMMENDATION 67

We recommend that a patient travel and accommodation assistance scheme be funded at a level that takes better account of the out-of-pocket costs of patients and their families and facilitates timely treatment and care.

**Additional cost** \$85 million (at current levels of demand) – \$244 million (at 2.25 times current demand)

**Costing assumptions** The cost of a nationally consistent Patient Travel Assistance Scheme (PTAS) has been based on research undertaken by PricewaterhouseCoopers in 2008<sup>272</sup> which features:

- subsidy of \$100 per night for both commercial and private accommodation with escorts eligible for 50 per cent of accommodation subsidy,
- rebate of 25 cents per kilometre for road travel,
- no co-payments for concession card holders,
- co-payment of first night’s accommodation (\$100) or first 100 km (\$25) for day trip for non-concession card holder.

Current expenditure was based on state and territory submissions to the Senate Enquiry<sup>273</sup> as well as Departments of Health Annual reports and detailed Patient Travel Assistance Scheme (PTAS) data from Queensland Health. Northern Territory, ACT and Tasmanian data was insufficient to undertake a full analysis so the average increase from the other states (Queensland, Western Australia, New South Wales, Victoria and South Australia) was extrapolated to estimate the potential cost of the scheme across Australia.

272 PricewaterhouseCoopers, 2008 High level cost of a National Patient Travel Assistance Scheme unpublished

273 The Senate Standing Committee on Community Affairs: Highway to health: better access for rural, regional and remote patients

## RECOMMENDATION 70

We recommend that the Clinical Education and Training Agency take the lead in developing an integrated package of strategies to improve the distribution of the health workforce. This package could include strategies such as providing university fee relief, periodic study leave, locum support, expansion of medical bonded scholarships and extension of the model to all health professions; preferential access for remote and rural practitioners to training provided by specialty colleges recognising related prior learning and clinical experience and/or work opportunities for practitioners returning to the city and support for those who plan to return again to remote or rural practice once specialty attained.

**Annual cost** \$27 million

**Costing Assumptions** We have not had the opportunity to estimate the cost of the many different initiatives contained within this recommendation. The indicative cost shown is a doubling of the 2009–10 Budget allocation of \$26.7 million to expand the scope of incentives for rural general practitioners, as extending these to other rural health professionals would at least double the potential target population.

## RECOMMENDATION 71

We recommend that a patient travel and accommodation assistance scheme be funded at a level that takes better a We recommend that a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service. ccount of the out-of-pocket costs of patients and their families and facilitates timely treatment and care.

**Annual cost** \$30 million  
\$30 million capital

**Costing Assumptions** 30 Communities of Youth Services in all states and territories have been established by way of grant funds averaging \$950,000 through *headspace*<sup>274</sup>. Expanding the program by establishing another 30 communities would cost \$30 million in capital and \$30 million in ongoing funding.

Communities of Youth Services are currently funded through a mix of MBS, PBS and grant funds. Each community requires about \$500,000 per year operating funds.

Ongoing funding for the communities may be included in the recent announcement<sup>275</sup> of continued funding of *headspace* of \$35.6 m over 3 years from July 2009 once *headspace* had repositioned itself as independent company

Some *headspace*, such as *headspace Goldcoast* are already promoting access to sexual health advice from their GPs.

274 [http://www.headspace.org.au/\\_uploads/documents/Microsoft%20Word%20-%202008%20YSDF%20plain%20language%20summary%20of%20grants\\_Final%20\\_3\\_.pdf](http://www.headspace.org.au/_uploads/documents/Microsoft%20Word%20-%202008%20YSDF%20plain%20language%20summary%20of%20grants_Final%20_3_.pdf)

275 [http://www.headspace.org.au/\\_uploads/documents/2008%20media%20releases/MediaRelease121208MinsterRoxon.pdf](http://www.headspace.org.au/_uploads/documents/2008%20media%20releases/MediaRelease121208MinsterRoxon.pdf)

## RECOMMENDATION 72

We recommend that the Early Psychosis Prevention and Intervention Centre model be implemented nationally so that early intervention in psychosis becomes the norm.

<b>Annual cost</b>	\$26 million net of estimated Victorian YEP program
Costing Assumptions	<p>The Victorian Youth Early Psychosis (YEP) program is targeted at young people aged between 16 and 25.</p> <p>There were 695,000 Victorians aged between 16 and 25 in June 2008 and nationally there were 2.836 million.</p> <p>Dedicated funding for new regional YEP services totalled \$5.5 million<sup>276</sup> in 2006–07 in addition to EPPIC CCT and EPPIC state-wide with total funding estimated at \$8.5 million. The service is funded as part of COAG National Action Plan for Mental Health 2006-2011.<sup>277</sup></p> <p>The cost of implementing the YEP service nationally has been based on the Victorian funding per youth of \$12. This may over estimate the cost as it has not been possible to determine if other states include similar services in their early intervention services for young people.</p>

## RECOMMENDATION 73

We recommend that every acute mental health service have a rapid-response outreach team for those individuals experiencing psychosis, and subsequently have the acute service capacity to provide appropriate treatment.

<b>Annual cost</b>	\$200 million
Costing Assumptions	It has not been possible to cost this recommendation as data is not readily available on the current level of service provision. However the Mental Health Council of Australia has estimated the expenditure required for designated teams to provide in-home acute care at \$200 million per year. <sup>278</sup>

## RECOMMENDATION 74

We recommend that every hospital-based mental health service should be linked with a multi-disciplinary community-based sub-acute service that supports 'stepped' prevention and recovery care.

<b>Annual cost</b>	\$70 million
Costing Assumptions	It has not been possible to cost this recommendation as data is not readily available on the current level of service provision however the Mental Health Council of Australia has estimated the expenditure required for step up/step down accommodation options at \$70 million per year. <sup>279</sup>

276 <http://www.health.vic.gov.au/mentalhealth/psychosis/yep-report-07.pdf>

277 [http://coag.gov.au/reports/docs/AHMC\\_COAG\\_mental\\_health.doc](http://coag.gov.au/reports/docs/AHMC_COAG_mental_health.doc)

278 Mental Health Council of Australia (2006) Time for service

279 Mental Health Council of Australia (2006) Time for service

## RECOMMENDATION 77

We want governments to increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support.

**Annual cost** \$7 million

**Costing Assumptions** The Australian Government has committed to funding of \$39.8 million to help people with a mental illness enter and remain in employment as part of COAG National Action Plan for Mental Health 2006–2011.<sup>280</sup>

Doubling the annual 2006–07 allocation of \$6.51 million would significantly increase the investment in vocational rehabilitation and post-placement employment support.

## RECOMMENDATION 78

As a matter of some urgency, governments must collaborate to develop a strategy for ensuring that older Australians, including those residing in aged care facilities, have adequate access to specialty mental health and dementia care services.

**Annual cost** \$23 million

**Costing Assumptions** The New South Wales Government has committed to funding of \$37.3 million for specialist assessment of the needs of older people as part of COAG National Action Plan for Mental Health 2006–2011.<sup>281</sup>

The cost of implementing this recommendation has been based on the full year funding of the New South Wales service across the 2008 population aged 80 years and over.

## RECOMMENDATION 83

We recommend that all Australians should have universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay. This should occur through the establishment of the 'Denticare Australia' scheme. Under the 'Denticare Australia' scheme people will be able to select between private or public dental health plans. 'Denticare Australia' would meet the costs in both cases. The additional costs of Denticare could be funded by an increase in the Medicare Levy of 0.75 per cent of taxable income.

**Additional cost** The net additional cost to government of funding this recommendation is nil, if the government chooses to implement the proposed increase in the Medicare Levy. The total annual cost of dental services within scope is \$5.5bn (including \$200m for dental residency program, \$100m school dental expansion and \$20m oral health promotion), of which the government would meet \$4.9bn. Existing direct government funding of dental services is about \$1 billion. The additional cost to government of the scheme is therefore \$3.9bn, which could be fully funded by a 0.75 per cent levy of taxable income, with a small additional amount for growth of private dental of about 5 per cent.

280 [http://coag.gov.au/reports/docs/AHMC\\_COAG\\_mental\\_health.doc](http://coag.gov.au/reports/docs/AHMC_COAG_mental_health.doc)

281 [http://coag.gov.au/reports/docs/AHMC\\_COAG\\_mental\\_health.doc](http://coag.gov.au/reports/docs/AHMC_COAG_mental_health.doc)

Costing Assumptions The scope of dental services to be covered by the Scheme includes restorative, preventative, diagnostic services and extractions, dentures and existing public dental services.

The scheme will fund 100 per cent of the cost of services within scope delivered by public dental practitioners and 85 per cent of those delivered by private dental practitioners.

The estimate of the total annual cost of the scheme is based on 2005–06 expenditure on dental care adjusted for the medical threshold tax rebate, Commonwealth dental plan and teen Dental Plan, updated with 2006–07 data and estimates of population growth, population ageing and increases in dental visits and services arising from higher income to provide a 2008–09 baseline.<sup>282</sup>

Existing direct government funding of dental services is about \$1 billion.

It is assumed that all those that currently use private dental practitioners will opt for a private plan under Denticare.

There is scope for limited expansion (about 5 per cent) in the supply of private dental services early in the scheme and public dental services increase by about 50 per cent, if a levy set at 0.75 per cent of taxable income is used to fund the scheme (equivalent to funding of \$4.1 billion).

In addition no savings have been factored into the costing due to a reduction in the current proportion of private health insurance (PHI) rebates that are attributable to insurance for dental care (approx \$470 million pa). In practice, as many of the dental costs met currently through private health insurance would be covered by Denticare Australia, it is reasonable to suppose that people's expenditure on premiums for private dental cover would reduce, with a proportionate saving to government outlays on PHI rebates. These reductions in PHI rebates could also be applied to growth in services under Denticare of more than 5 per cent, at no net additional cost to government.

## RECOMMENDATION 84

We recommend the introduction of a one-year internship scheme prior to full registration, so that clinical preparation of oral health practitioners (dentists, dental therapists and dental hygienists) operates under a similar model to medical practitioners. This will require an investment in training and capital infrastructure.

**Additional cost** \$200 million operating costs  
\$150 million capital costs per year for 5 years

Costing Assumptions In order to build the capacity of the hubs (i.e. dental teaching hospitals) a new hub would be required each year for five years. The spokes, or academic oral health service centres, barely exist at present. Some 10 such centres would need to be established each year for five years to build the capacity toward the 700 graduate residents. These developments would require some \$150 million p.a. The full operating cost of the residency program would be of the order of \$200 million p.a. About half this cost is for residents' salaries and the remainder for appropriate support for the residency program and their service provision.<sup>283,284</sup>

282 Price Waterhouse Coopers 2008, Costing a Social Insurance Scheme for Dental Care

283 John Spencer Discussion Paper for NHRC 2008, Improving Oral Health and Dental Care for Australians

284 Price Waterhouse Coopers 2008, Costing a Social Insurance Scheme for Dental Care

## RECOMMENDATION 85

We recommend the national expansion of the pre-school and school dental programs.

**Additional cost** \$100 million  
\$50 million capital costs per year for 5 years

**Costing Assumptions** A revitalization of the school dental services could be partially accommodated within the proposed dental residency program, but would require additional funds to build specific infrastructure, for instance linked to the emerging super schools and new oral health service centres, and to an expansion of the numbers of dental therapists employed. Existing infrastructure is also ageing and a revitalization and extension of the school dental services infrastructure might require a total of \$50 million p.a. for five years. It is estimated that the school dental services have a recurrent cost of approximately \$100 million p.a. A 100 per cent expansion of their coverage of primary and secondary school children would require \$100 million total from all levels of government.<sup>285,286</sup>

## RECOMMENDATION 86

We recommend that additional funding be made available for improved oral health promotion, with interventions to be decided based upon relative cost-effectiveness assessment.

**Additional cost** \$20 million

**Costing Assumptions** The cost of stimulating oral health promotion activities would be modest. A recurrent expenditure of some \$20 million p.a. would dramatically increase the levels of integration of oral health into general health promotion and specific oral health promotion activities.<sup>287,288</sup>

## RECOMMENDATION 88.9

The Commonwealth, state and territory governments would agree to establish national approaches to health workforce planning and education, professional registration, patient safety and quality (including service accreditation), e-health, performance reporting (including the provision of publicly available data on the performance of all aspects of the health system), prevention and health promotion, private hospital regulation and health intervention and technology assessment.

**Annual cost** \$25 million in addition to the national functions costed in other recommendations

285 Draws on John Spencer Discussion Paper for NHHRC 2008, Improving Oral Health and Dental Care for Australians

286 Price Waterhouse Coopers 2008, Costing a Social Insurance Scheme for Dental Care

287 Draws on John Spencer Discussion Paper for NHHRC 2008, Improving Oral Health and Dental Care for Australians

288 Price Waterhouse Coopers 2008, Costing a Social Insurance Scheme for Dental Care

## Costing Assumptions

<b>Proposed national functions</b>		<b>Estimated annual cost</b>
<b>#</b>		<b>\$'000</b>
111	National Safety & Quality in Health Care	34000
9	National Health Promotion and Prevention	100000
	National Health Intervention Assessment	20000
	National Private Hospital Regulation	5000
109	National Health Innovation	8000
33	National Performance Reporting and Accountability Framework	12000
61	National Aboriginal and Torres Strait Islander Health Authority	58368
		237368

**National safety and quality in health care** is detailed in Recommendation 111, **national health promotion and prevention** in Recommendation 9, **national health innovation** in Recommendation 109, **national performance reporting and accountability** in recommendation 33 and **National Aboriginal and Torres Strait Islander Authority** in recommendation 61.

The proposed national functions estimated funding requirements are based on the current level of Commonwealth government funding of current national health bodies together with their reported operating expenses in 2007-08<sup>289,290</sup>.

The net additional cost of national **registration of health professionals** is proposed to be zero as government is already committed to funding this.

The net additional cost of national **clinical education and training** is proposed to be zero as COAG has made a commitment to fund this.

A number of national bodies currently exist and their funding could be increased to reflect their expanded functions such as MSAC and PBAC and national **health intervention assessment**, National Institute of Clinical Studies (now part of NHMRC) and **national health innovation**, Australian Institute of Health and Welfare and **national performance reporting**.

Other functions such as **national private hospital regulation** costs could well be offset by a transfer of state funding as regulation is now done on a state by state basis.

289 [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009\\_Health\\_PBS](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009_Health_PBS)

290 <http://www.dva.gov.au/media/aboutus/annrep08/pdf/outcome2.pdf>

## RECOMMENDATION 97

Additional capital investment will be required on a transitional basis to facilitate our recommendations. In particular, we recommend that: priority areas for new capital investment should include: the establishment of Comprehensive Primary Health Care Centres and Services; an expansion of sub-acute services including both inpatient and community-based services; investments to support expansion of clinical education across clinical service settings; and targeted investments in public hospitals to support reshaping of roles and functions, clinical process redesign and a reorientation towards community-based care; and capital can be raised through both government and private financing options. The ongoing cost of capital should be factored into all service payments.

**Capital cost** \$1350–\$2650 million (in addition to capital requirements costed in other recommendations)

### Costing Assumptions

17.	Comprehensive Primary Health Care Centres	\$300m
38.	Sub-acute infrastructure expansion	\$900–\$1500m
71.	Communities of youth health services	\$30m
84.	Dental training facilities for residency	\$375–\$750m
85.	School dental service expansion	\$125–\$250m

The following two initiatives have not been costed in other recommendations and are included in this section.

Clinical education and training facilities expansion	\$100–\$150m
Hospitals to be used for reshaping of roles and functions and clinical process redesign with a particular emphasis on dedicated elective surgical units and emergency department efficiency.	\$1250–\$2500m

Identified Government capital expenditure has historically varied little as a percentage of recurrent health expenditure and averaged 7.9 per cent for public acute hospitals for the decade ended 1999–2000.<sup>291</sup>

Redevelopment of hospitals has been based on 30-90 per cent of the cost of an equivalent new hospital, dependent on age and quality of the building stock, services and other infrastructure.<sup>292</sup>

291 John Deeble 2000 Capital investment in public hospitals  
 292 Department of Health Vic Hospital Capital Planning

## RECOMMENDATION 99

To improve access to care and reflect current and evolving clinical practice we recommend that: Medicare rebates should apply to relevant diagnostic services and specialist medical services ordered or referred by nurse practitioners and other health professionals having regard to defined scopes of practice determined by recognised health professional certification bodies. Pharmaceutical Benefits Scheme subsidies (or, where more appropriate, support for access to subsidised pharmaceuticals under section 100 of the National Health Act 1953) should apply to pharmaceuticals prescribed from approved formularies by nurse practitioners and other registered health professionals according to defined scopes of practice. Where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialled for defined scopes of practice.

**Annual cost** \$140–\$330 million in addition to \$22.5 million allocated to fund the expansion of MBS and PBS to nurse practitioners and midwives in 2010–11

**Costing Assumptions** This assumes a constant number of practice nurse services, plus practice nurses would not prescribe (as they are in a GP practice, and if they did prescribe it would be on behalf of the GP).

The limit of 12 psychological therapy services would be retained so there would be no net change in the number of psychological services.

The number of other allied health services provided under a GP EPC plan or some other arrangement but using similarly priced MBS items would double.

Psychologists and other allied health services would prescribe and order tests in addition to the GP ordering, at 25 per cent of the rate at which GPs order<sup>293</sup>.

As most specialist are fully engaged, it is assumed that the capacity of health professionals other than doctors to refer to specialists will improve efficiency, and may enable some patients to attend specialists who would not otherwise have done so, but would not add to costs but simply shift waiting times.

Access to MBS benefits for procedures by providers other than nurses will be small. For nurses however this is more difficult, and depends on their scopes of practice. For costing purposes it is assumed procedural work would add \$200 to MBS for 5 per cent of services (excluding practice nurses and psychologists).

If nurses and wider incentives were covered by the program the number of referred allied health services would increase by a factor of five with all other assumptions fixed; additional cost of \$330m per annum would apply.

These costs are only MBS & PBS and do not include out of pocket patient costs nor any offsets to currently publicly provided services.

\$22.5 million has been allocated for 2010–11 in the Australian Government Budget 2009–10 to fund the expansion of MBS and PBS to nurse practitioners outside acute care and midwives in collaborative models of care.<sup>294</sup>

293 Extrapolated from Medicare Australia Annual Report 2007-08

294 DoHA 2009–10 Budget

## RECOMMENDATION 100

We recommend a new education framework for all education and training of health professionals: moving towards a flexible, multi-disciplinary approach to the education and training of all health professionals; incorporating an agreed multi-disciplinary approach to the education and training of all health professionals; incorporating an agreed competency-based framework as part of a broad teaching and learning curricula for all health professionals; establishing a dedicated funding stream for clinical placements for undergraduate and postgraduate students; and ensuring clinical training infrastructure across all settings (public and private, hospitals, primary health care and other community settings).

**Additional cost** The net additional cost of this may be nil, as COAG<sup>295</sup> has committed additional funding for undergraduate and postgraduate clinical training and clinical training infrastructure as part of the health workforce reform package. Accordingly the Commission proposal does not entail additional expenditure above what would be required by the existing commitment.

### Costing Assumptions

#### Commonwealth funding for clinical training subsidies<sup>296</sup>

	2009-10	2010-11	2011-12	2012-13
	\$m	\$m	\$m	\$m
Clinical training subsidy – undergraduates	67.48	140.25	143.66	145.08
Clinical training subsidy – postgraduates			32.81	53.42
Clinical training – supervision capacity	4	6	8	10
Clinical training simulated learning environments	0.25	7.48	20	20.75
<b>Total</b>	<b>71.73</b>	<b>153.73</b>	<b>204.47</b>	<b>229.25</b>

## RECOMMENDATION 101

To ensure better collaboration, communication and planning between the health services and health education and training sectors we recommend the establishment of a National Clinical Education and Training Agency: to advise on the education and training requirements for each region; to assist with planning clinical education infrastructure across all service settings including rural and remote areas; to form partnerships with local universities, vocational education and training organisations, and professional colleges, to acquire clinical education placements from health service providers, including a framework for activity-based payments for undergraduates' clinical education and postgraduate training; to promote innovation in education and training of the health workforce; as a facilitator for the provision of modular competency-based programs to up-skill health professionals (medical, nursing, allied health and aboriginal health workers) in regional, rural and remote Australia; and to report every three years on the appropriateness of accreditation standards in each profession in terms of innovation around meeting the emerging health care needs of the community. Further we recommend that the governance, management and operations of the Agency should include a balance of clinical and educational expertise, public and private health services representation in combination with Commonwealth and state health agencies. While the Agency has an overarching leadership function it should support implementation and innovation at the local level.

295 [http://coag.gov.au/coag\\_meeting\\_outcomes/2008-11-29/attachments.cfm#attachmenta](http://coag.gov.au/coag_meeting_outcomes/2008-11-29/attachments.cfm#attachmenta)

296 National Partnership Agreement on Hospital and Health Workforce Reform

**Additional cost** The net additional cost of this recommendation may be nil, as COAG<sup>297</sup> has committed additional funding for undergraduate and postgraduate clinical training and clinical training infrastructure as part of the health workforce reform package. Accordingly the Commission proposal does not entail additional expenditure above what would be required by the existing commitment.

#### Costing Assumptions

#### Commonwealth funding for National Health Workforce Agency<sup>298</sup>

	2009-10	2010-11	2011-12	2012-13
	\$m	\$m	\$m	\$m
National Health Workforce Agency	25	30	35	35
Workforce redesign	20	30	15	6

#### RECOMMENDATION 102

We support national registration to benefit the delivery of health care across Australia.

**Additional cost** The net additional cost of this is proposed to be zero, as government has already made a prior commitment to national registration of health professionals. Accordingly the Commission's proposal does not entail additional expenditure above what would be required by the existing commitment.

#### RECOMMENDATION 104

We recommend that a higher proportion of new health professional educational undergraduate and postgraduate places across all disciplines be allocated to remote and rural regional centres, where possible in a multidisciplinary facility built on models such as clinical schools or university departments of Rural Health.

**Additional cost** The net additional cost of this is proposed to be zero, as government has already made a prior commitment of \$40 million in capital infrastructure funding to establish or expand education and training at major regional hospitals as part of the Rural Clinical Program.<sup>299</sup>

297 [http://coag.gov.au/coag\\_meeting\\_outcomes/2008-11-29/attachments.cfm#attachmenta](http://coag.gov.au/coag_meeting_outcomes/2008-11-29/attachments.cfm#attachmenta)

298 National Partnership Agreement on Hospital and Health Workforce Reform

299 National Partnership Agreement on Hospital and Health Workforce Reform

## RECOMMENDATION 105

To promote research and uptake of research findings in clinical practice, we recommend that clinical and health services research be given higher priority. In particular we recommend that the Commonwealth increase the availability of part-time clinical research fellowships across all health sectors to ensure protected time for research to contribute to this endeavour.

**Additional cost** \$100 million

**Costing Assumptions** The NHMRC's planned funding commitments for health and medical research in Australia over the Budget and forward estimates is expected to rise to over \$880 million in 2010 and then stabilise at around \$780 million over the next three years, with 63 per cent of funding supporting research projects, 25 per cent supporting capacity building fellowships and scholarships, and 12 per cent supporting the translation of health and medical research into evidence-based practice.<sup>300</sup>

NHMRC funding has been around 1.3 per cent of all Health and Ageing portfolio in recent years. Using departmental estimates for spending to 2011–12 and then projecting portfolio and NHMRC spending forward based on those growth rates, NHMRC funding should reach \$890 million by 2014–15.<sup>301</sup> A further \$100 million per year is needed to reach this level of funding.

## RECOMMENDATION 109

To enhance the spread of innovation across public and private health services, we recommend that: the National Institute of Clinical Studies broaden its remit to include a 'clearinghouse' function to collate and disseminate innovation in the delivery of safe and high quality health care; health services and health professionals share best practice lessons by participating in forums such as breakthrough collaboratives, clinical forums, health roundtables, and the like; and a national health care quality innovation awards program is established.

**Additional cost** \$8 million

**Costing Assumptions** The proposed national function estimated funding requirement is based on the current level of Australian government funding of existing national health bodies

300 DOHA 2009–10 Budget National Health and Medical Research Council, At: [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2009-2010\\_Health\\_PBS\\_sup1/\\$File/Department%20of%20Health%20and%20Ageing%20PBS.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2009-2010_Health_PBS_sup1/$File/Department%20of%20Health%20and%20Ageing%20PBS.pdf)

301 Research Australia (2009), Trends in Health and Medical research Funding

## RECOMMENDATION 111

The Australian Commission for Safety and Quality in Health Care should be established as a permanent, independent national body. With a mission to measurably improve the safety and quality of health care the ACS&QHC would be an authoritative knowledge-based organisation responsible for: Promoting a culture of safety and quality across the system: disseminating and promoting innovation, evidence and quality improvement tools; recommending national data sets with a focus on the measurement of safety and quality; identifying and recommending priorities for research and action; advocating for safety and quality; providing advice to governments, bodies (e.g. NHMRC, TGA), clinicians and managers on 'best practice' to drive quality improvement. Analyse and report on safety and quality across all health settings: reporting and public commentary on policies, progress and trends in relation safety and quality; develop and conduct national patient experience surveys; report on patient reported outcome measures. Monitor and assist in regulation for safety and quality: recommending nationally agreed standards for safety and quality, including collection and analysis of data on compliance against these standards. The extent of such regulatory responsibilities requires further consideration of other compliance activities such as accreditation and registration processes.

**Additional cost** \$34 million

**Costing Assumptions** The estimated funding requirement for the proposed national function is based on the current level of Australian government funding of current national health bodies.

The Australian Commission on Safety and Quality in Health Care is currently funded at \$11 million however this needs to be ongoing and needs to reflect an expanded role including accreditation, registration, promotion and reporting.

## RECOMMENDATION 123

With respect to the broader e-health agenda in Australia, we concur with, and endorse the directions of the National E-Health Strategy Summary (December 2008), and would add that: There is a critical need to strengthen the leadership, governance and level of resources committed by governments to giving effect to the planned National E-Health Action Plan. This Action Plan must include provision of support to public health organisations and incentives to private providers to augment uptake and successful implementation of compliant e-health systems. It should not require government involvement with designing, buying or operating IT systems. In accordance with the outcome of the 2020 Summit and our direction to encourage greater patient involvement in their own health care, that governments collaborate to resource a national health knowledge web portal (comprising e-tools for self-help) for the public as well as for providers. The National Health Call Centre Network (healthdirect) may provide the logical platform for delivery of this initiative. Electronic prescribing and medication management capability should be prioritised and coordinated nationally, perhaps by development of existing applications (such as PBS online), to reduce medication incidents and facilitate consumer amenity.

**Additional cost** \$1,185–\$1,865 million

**Costing Assumptions** \$600–\$900 million implementation and adoption of national standards including:

- investment in bringing existing public and private systems to a level that will allow them to operate with a broader electronic health care system, including interfaces;
- encouragement of the development and implementation of new e-health solutions that apply these standards and implement the interfaces necessary to allow broad integration. This would include solutions

to allow consumers access to and use of their own personal health information.

- Implementation of additional enablers of national information exchange, such as national indexing, strong privacy management and authentication services.
- Investment in the industry infrastructure required to test and accredit the adoption of eHealth.

\$500–\$800 million e-health teaching, training, change management and support to health care practitioners targeting:

- encouragement of the active use of high priority e-Health solutions prior to the mandated use of these solutions to provide data that can be integrated into a person-controlled electronic health record (such investment does not replace investments by the private and public sector in the development of their internal e-health solutions, but helps ensure that they can contribute to the national system);
- health information training for clinicians, including in universities, continuing education and in specialist health contexts (such as hospital emergency departments);
- workplace change, enabling new workplace practices that can only be adopted with e-health solutions in-place;
- delivery of new tools and capabilities that leverage e-health information to deliver provider efficiencies (e.g. new electronic clinical registries) and enhanced health monitoring (such as bio-surveillance capabilities).

\$35–\$65 million consumer marketing program

\$50–\$100 million research, performance monitoring and governance

These costs are in addition to developments to date funded by COAG commitments of \$318m and industry and individual practitioner investment and do not include hospital information system infrastructure.<sup>302</sup>

