

## **Intergovernmental Agreements: Update on Reforms on Risk Adjustment of Health Funding and Evidence Based Medicine (EBM) Implementation**

### **Background**

Current key Federal government political imperatives are to invest for the future in initiatives that can lead to savings to facilitate growth and help return the budget to surplus. This paper addresses this urgent imperative in the area of health care.

The paper entitled *Integrating economic and clinical evidence, Guidelines and equity into national regulation and financing: reforms for the Australian Health Care Agreements: 2009 and beyond* (Antioch, 2008) was forwarded to key Federal and State government stakeholders in October 2008. Several stakeholders advised that they considered the document along with the COAG Working Group papers for the November 2008 COAG meeting. The paper included feedback on the reforms from national and international stakeholders over the period 2006 to 2008.

There have been some key recent developments relating to the abovementioned paper regarding risk adjustment reform for Activity Based Funding following feedback from the NT Health Minister about this matter.

Recently, cost savings have been calculated for the other reform in the paper concerning the implementation of Evidence Based Medicine, the translation of cost effectiveness and clinical effectiveness evidence into clinical practice through the implementation of State/Territory Centres for such work. Based on the achieved cost savings estimated for such work in Victoria, given reductions in average length of stay (ALOS) and reductions in adverse events, the total cost savings from the national roll out of such centres are \$273.524m annually or \$1,367.620m over five years.

This paper addresses these issues and places the reform agenda in the current policy context now that the Inter governmental Agreements (IGAs) have been agreed and the Interim Report of the National Health and Hospitals Reform Commission has been released and the Federal Government budget will be announced on 12 May, 2009.

A key focus on health costs is important. Health spending was 9% of GDP in 2006-07 up from 7.7% of GDP over 10 years. The challenge is to pay for increasing health requirements and treatments by running the system more efficiently. Improved productivity is the key<sup>1</sup>. This paper offers the potential to significantly improve efficiency in Australian health care. The reform can address the key question raised by the Federal Treasurer in the media on *'how do we do what's right now, while still making the long term structural saves for sustainability sake'?*<sup>2</sup>

### **Issues**

#### **1. Recent COAG Meetings**

Commonwealth-State financial relations were recently placed on a secure footing with the creation of five new national Specific Purpose Payments, including \$60.5b in a new National Health Specific Purpose Payments (SPP). Total commonwealth funding for health is \$64.4b over five years.

Each National Agreement and SPP contains the objectives, outcomes, outputs and performance indicators and clarifies the roles and responsibilities that will guide the Commonwealth and States in the delivery of services across the relevant sectors. New National Partnerships (NP) Payment will fund specific projects and facilitate or reward performance, funding for which will be decided at a later date. The first wave of related NPs will be in 2009 and includes:

- Hospital and health workforce reform
- Preventive health
- Taking pressure off public hospitals
- Indigenous remote service delivery

New financial frameworks began in January 2009 and provide the solid foundation for COAG. The new National SPPs will be distributed among states on an equal per capita basis phased over five years. The new index formulae delivers 7.3% per year compared with 5.3% under the previous agreement. COAG requested officials to bring back specific proposals in relation to community, mental health, disability services and aged care in the first half of 2009 as part of this program (COAG 2008).

<sup>1</sup> *The Australian*, (2009) 'A productivity Cure: We need ways to stretch the health dollar much further'. 6 May, 2009 page 17.

<sup>2</sup> Tingle, L 'Health, aging costs tip budget reform agenda: Swan, *The Australian Financial Review*, pg 1 and 10, 8 May, 2009

On February 2009, COAG held a special meeting to ensure rapid delivery of economic stimulus to support employment and growth in several sectors of the economy and to foster a more resilient Australia (COAG, 2009a). Given the constraints of the global financial crisis, COAG has looked to encourage productivity enhancing projects for the April COAG 2009 meeting. At that meeting, COAG also agreed on a national approach to prepare for and manage the impacts of, an influenza pandemic in Australia (COAG, 2009b)

## **2. Reforming the Australian Health Care Agreements: feedback from Australian jurisdictions**

The paper entitled “*Integrating economic and clinical evidence, Guidelines and equity into national regulation and financing: reforms for the Australian Health Care Agreements: 2009 and beyond*” (Antioch, 2008) received attention by all States and Territories during October and November 2008 and there has been follow-up and feedback by some stakeholders to date. The paper discussed two reforms, viz the risk (severity) adjustment of the formulae of the AHCA and also the implementation of a program involving State and Territory Centres to undertake work relating to Evidence Based Medicine (EBM) and Clinical Practice Guideline (CPG) implementation for all health sectors. The nature of the stakeholder feedback on the reforms, the implications of the reforms in the agreed IGAs, Reform Commission’s interim report and Commonwealth and State budgets are considered below.

### **(a) Risk Adjustment and Activity Based Funding (ABF)**

The Northern Territory Health Minister wrote to Dr Antioch during February 2009 indicating interest in the application of risk adjustment for the national implementation of Activity Based Funding (ABF). A copy of his letter is attached, with that health minister’s approval, for your consideration. During February, 2009 copies of this correspondence were also forwarded to Federal Ministers for Finance and Deregulation; Health and Aged Care, Federal Treasurer and Secretary of Prime Minister and Cabinet. The Victorian Health Minister, Treasurer and Premier also received a copy.

By way of background, the risk adjustment reforms under casemix funding arrangements (also described as Activity Based Funding) that were applied in Victoria for funding negotiations by Bayside Health with the Victorian Department of Human Services, cited in Antioch (2008), were applied at that health service at the same time that the EBM initiatives were applied across that hospital network. Antioch, Ellis and Gillett et al (2007)<sup>3</sup> provide a brief overview of such risk adjustment negotiations and the results of State-wide analysis across all major teaching hospitals by the Victorian Government’s Risk Adjustment Working Group (RAWG), chaired by Dr Kathryn Antioch. (See also Antioch and Walsh, 2004, 2002, 2000) for details of the risk adjustment analyses which formed the basis of the negotiations with the Victorian government. Antioch et al (2007) also discusses the implemented risk adjustment of the complexity component of the Training and Development grant, which is an important feature of casemix funding arrangements in Victoria.

The risk adjustment reforms enable greater equity in health financing since risk adjustment is required for AR-DRGs that may be underfunded since they can be related to State-wide referral services such as trauma, heart transplants, lung transplants and Cystic Fibrosis in hospital networks, where the averaging process in the cost weight process State-wide, does not adequately capture the differences in casemix of such DRGs.

Risk adjustment also offers the opportunity to align indigenous and other socio-economic disadvantage and related health need to appropriate funding levels (Van de Ven and Ellis 2000).

Additionally, the EBM approach enabled greater cost-effectiveness at the point of care at Bayside Health and Western Health increasing technical efficiency. Improved health outcomes are enabled through more cost-effective use of the available funds. This paper more fully explores the EBM reform issue.

### **(b) Evidence Based Medicine reforms and establishment of State/Territory Centres**

The paper by Antioch (2008) identified that for the EBM initiatives at Western Health, Victoria, there were annual savings of \$5.1m per annum calculated by costing the reductions in average length of stay (ALOS) and adverse events for those AR-DRGs related to the EBM initiatives. Potential cost savings for the hospital sector have been calculated if the EBM vision was rolled out nationally based on national application of the average cost savings that are pro rated per separation across the hospital network of Western Hospital. Based on the AIHW data on total hospital separations Australia-wide in

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<sup>3</sup> Antioch, Ellis and Gillett et al (2007) [http://people.bu.edu/ellisrp/EllisPapers/2007\\_AntiochEllisGillett\\_EJHE\\_RiskAd.j.pdf](http://people.bu.edu/ellisrp/EllisPapers/2007_AntiochEllisGillett_EJHE_RiskAd.j.pdf) for a brief overview of such negotiations.

2007, the cost savings are estimated at \$273.524m per annum and over five years to be \$1,367.620m<sup>4</sup>. These cost savings would need to be considered relative to total investment figure for the initiative to calculate the net cost savings. The State/Territory estimated cost savings are outlined below:

**Table 1: Hospital Cost Savings by State/Territory (Annual and 5 years)<sup>5</sup>  
Implementation of State/Territory Centres of Evidence Based Medicine, Health Services and Workforce Re-design**

State	Annual Cost Savings (\$)	5 Year Cost Savings (\$)
NSW	85,797,730	428,988,649
Victoria	77,119,721	385,598,603
Qld	46,042,088	230,210,442
WA	26,458,577	132,292,886
SA	22,923,166	114,615,830
Tas	5,701,114	28,505,570
ACT	4,446,008	22,230,038
NT	5,035,507	25,177,534
National	273,523,910	1,367,619,552

The EBM vision includes the following elements as outlined in Antioch (2008).

The proposed new program “*Evidence Based Medicine (EBM) and Clinical Practice Guideline implementation*”, including the establishment of State/Territory Centres would enable the implementation of the recommendations of the 2007 national seminar series “*Lessons on integrating economic and clinical evidence into clinical practice*” to roll out such Victorian methodology Australia-wide. These seminars, in all States and Territories and New Zealand, were sponsored by the Australian Health Care Association and the Womens and Childrens’ Hospital Australasia and related to the implementation of hospital based evidence based medicine and service redesign initiatives in the health services of Bayside Health and Western Health. Other State reform synergies could also be integrated in the nature of the proposed Centres to be established, such as the *Clinical Network Evidence Based Practice* and *Redesigning Hospital Care Programs* in Victoria (Antioch, 2008).

The national seminars covered the methodological issues in applying health economics (cost effectiveness) and clinical effectiveness evidence in developing and implementing Clinical Practice Guidelines in hospitals through clinical pathways, protocols (ie algorithms) and management plans. They also addressed change management and clinical governance processes used successfully within complex organizations such as hospitals and with the medical profession. The advantages of various types of clinical governance models implemented across six hospitals were explored along with the establishment of the Guidelines and Economists Network International (GENI). Further details are shown in Antioch (2008).

The required capital and service infrastructure could be used by the States to enable the creation of ‘*State Centres in Evidence Based Medicine, Health Services and Workforce Redesign*’<sup>6</sup> involving Technology solutions, change management techniques (organizational change), and clinical and EBM experience in various sectors of the health industry. The State level organizations should also build into their plans the capacity to link across the comparable organization in other States and internationally. Importantly, the state organizations could enable expert staff to work collaboratively with institutions such as hospitals, aged care facilities and Chronic Disease Management (CDM) and other community health organizations to implement best practice medicine at the point of care. There would be considerable synergies and economies of scale whereby the Centres can consolidate information regarding the evidence base, Information Technology solutions such as the *Map of Medicine* and very promising NSW IT systems for hospitals, Clinical Practice Guidelines, EBM translational techniques using NHMRC (1999, 2000, 2001) and other international methodology, organization change, and training capacity in one center with outreach across the system in each State (Antioch, 2008). They could also link nationally to the new National Health Workforce Agency specified in COAG (2008)

<sup>4</sup> Based on total separations at Western Health of 86,907 and cost savings of \$5.1m Average cost savings across all separations is \$58.68 per separation. This was applied across total national separations during 2007 of 4,661,280 separations (AIHW, 2007). Given the proposed State/Territory Centres extend beyond hospitals, the overall cost savings are expected to be substantially higher. Hence the cost savings estimate is conservative. Western Health includes patients of low socio-economic status in Victoria and represents a challenging casemix to treat.

<sup>5</sup> Costs shown in 2006 prices.

<sup>6</sup> The title of the ‘Centres’ discussed in Antioch (2008) has been clarified in the current paper.

There would be important linkages within each state to the various quality organizations such as Quality Councils and nationally possibly through the deliberations of the National Institute of Clinical Studies (NICS) of NHMRC and the Australian Council on Safety and Quality in Health Care. Expertise of staff at each state organization would involve health economics, economic evaluation, Evidence Based Medicine, health administration, clinical evaluation, Information Technology, health services research and links to international organizations such as the Guidelines and Economists Network International (GENI) (Antioch, 2008).

Importantly, the Centres would build upon the State level health reforms developed in each state, such as the Victorian Health Reform Package underway to enable synergies across all health services (hospital networks) to leverage off the Victorian and other reforms such as the *Redesigning Hospital Care Program* and the *Clinical Network Evidence Based Practice* initiatives being undertaken in 2008-09 (Victorian Department of Human Services, 2008). The clinical network programs in Victoria currently only relate to renal, maternity, emergency services, cancer and stroke. The proposed centres will be all encompassing to move beyond these state initiatives to enable a more international focus (Antioch, 2008).

They could also work effectively with NICS of the NHMRC, proposed NHMRC Partnership Centres of Excellence and with other organizations highlighted and/or proposed by the NHHRC such as Comprehensive Primary Health Care Centres, Aboriginal Community Controlled Health Services, National Aboriginal and Torres Strait Islander Health Authority and the National Health Promotion Agency.

The key imperative of the program of the of '*State Centres in Evidence Based Medicine, Health Services and Workforce Redesign*' would be to, inter alia,

- Enable expert staff to work collaboratively with institutions such as hospitals, aged care facilities and Chronic Disease Management (CDM) and other community health organizations to implement best practice medicine at the point of care
- Aim to improve quality and maximize quality of life by reducing adverse events, deaths and readmissions,
- Improve efficiency by reducing costs and average length of stay (ALOS) in hospitals.
- Increase throughput by greater streamlining of services and improve discharge planning to reduce waiting lists.
- Strengthen capacity for service provision across all health sectors.
- Foster a culture of responding to needs of patients and
- Improve the measurement of performance in this area (Antioch, 2008)

The Centres could involve expenditure that increases the uptake of Evidence Based Medicine & Clinical Practice Guidelines Implementation and falls into one or more of the following categories:

- Upgrading, modifying, relocating or refurbishing existing facilities in order to provide new change management services across the State for all health sectors.
- Construction of purpose built facilities, especially with a view to share facilities and EBM staff expertise across hospital networks in the state and other health sectors.
- Investment in service infrastructure such as information systems, assessment tools, clinical practice guidelines, organization and services re-engineering/ change management committees.
- Dedicated staffing to lead the Evidence Based Medicine translation process or service management with capacity for skill consolidation and sharing between hospitals and area health services.
- Time limited training and recruitment strategies to increase skills and availability in the relevant part of the workforce, and/or
- Instigating mechanisms to increase the transition services from admission through to discharge and home (Antioch, 2008).

The development of these proposals, should consider the relationship (if any) to Commonwealth/State programs such as those in the Home and Community Care, National Institute for Clinical Studies (NHMRC) Victorian Quality Council (and in the case of NSW the Clinical Excellence Commission) to ensure there is complementary roles rather than overlap (Antioch, 2008).

Clearly, each State and Territory could consider the relevance of the EBM vision and State/Territory Centres to their own deliberations and plans. Some State/Territories may have some statewide organizations designed to address innovations in the health care sector. In these instances, the key lesson is to ensure that *cost effectiveness evidence* is used in the process of translation evidence into clinical practice. This application of *cost effectiveness evidence* seems to be an area that is often overlooked in Australian initiatives based on the feedback from the sponsored AHHA presentations Australia-wide. The Centres should also ensure that they are more than simply '*virtual initiatives*'. The employment of staff to actively

work with, and train the industry workforce would be essential to enable sustainability of such innovation initiatives. This could enable the achievement of the key imperatives of the IGAs and the Reform Commission, which are discussed more fully below. This includes consideration of:

- (a) National Health Care Agreement (Schedule F)
- (b) National Partnership Agreements on Hospital and Health Workforce Reform
- (c) National Policy and Reform Objectives (Schedule E)
- (d) National Indigenous Reform Agreement (Schedule F)
- (e) National Partnership Agreement on Preventive Health.
- (f) National Health and Hospitals Reform Commission Interim Report (2008).

**(a) National Health Care Agreement (NHCA): Schedule F**

The EBM vision involving the creation of the State/Territory Centres, directly addresses clause 8 of the NHCA that states that the best available information will foster innovation and sharing of practices shown to be effective and will enable collaborative work to assist the national health of all Australians. It also addresses the objectives in Clause 13 (c) to enable Australians to receive high quality and affordable hospital and related care. The progress measures in the 'hospital and related care' at clause 16 (page A6) include, inter alia:

- Selected adverse events in acute and sub-acute care settings and
- Unplanned/unexpected readmissions within 28 days of selected surgical admissions

Progress measures such as readmissions and adverse events have already been measured and used for evaluations in the Victorian EBM initiatives and have been published.<sup>7</sup> Further, with regard to the progress measure for 'sustainability' at clause 16 (page A8), the progress measure called 'cost per casemix adjusted separation for both acute and non acute care episodes' has been measured for inpatient cases and monitored, with casemix adjustment achieved using analyses by DRG in some of the Victorian hospitals. The results for various DRGs have been published for the Alfred hospital and overall cost savings across Western Health calculated that arose from reductions in average length of stay and adverse events by DRG.

The imperatives at clause 27 (d) to provide reliable, timely and affordable access to safe, cost effective and high quality medicine have also been addressed in the EBM vision implemented in Victoria and a recent priority identified in clause 29 on social inclusion and indigenous health (a) and (b) (page A-12).

The 'Social Policy and Reform Directions' at Clause 30 of the NHCA in the column 'priority reform areas' on pages A 13 to A 16 are relevant as specified in the following sections of that Clause:

*Prevention:*

- Trial evidence based approaches to reducing key risk factor contribution to poor health outcomes, including indigenous communities.
- Develop an evidence base to increase the efficacy of funding allocations, ensuring appropriate growth in funding over time.

The related 'policy directions' for this priority reform areas are, inter alia, to improve surveillance of the risk factors and the evidence base to support interventions.

*Primary and Community Health:*

- Develop a **multidisciplinary health workforce** in the primary care sector to deliver **cost effective** and quality service. A related 'policy direction' is to improve safety and quality in primary and community care and (potentially) use e health tools to link providers and improve quality of care for the individuals.

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<sup>7</sup> Length of stay, costs, deaths and variances for various clinical pathways by DRG for The Alfred hospital of Bayside Health, have also been monitored and casemix adjusted and published and presented internationally.

### *Hospital and related care*

- Implement improvements in hospital quality and safety, building on the priorities of the Australian Commission on Safety and Quality in Health Care.

All of the specified ‘policy directions’ at page A 14 are relevant and the EBM vision and State/Territory Centres holds potential to improve waiting time for surgery and ED, technical efficiency, quality and safety and performance information and assessment and support of patients before admission and on discharge from acute care settings.

### *Patient Experience*

- Develop and implement patient assessment standards and transfer **protocols** including those for disadvantaged and at risk patients.

The ‘policy directions’ specified on page A 15 are related to the EBM vision given the importance to **‘develop nationally agreed clinical pathways for key conditions (chronic and complex) and implement and monitor across the health system’**.

The lessons from the Victorian experience are that any generic, nationally agreed clinical pathway would need to be locally modified to account and provide for local differences in hospital related network strategies and needs e.g. discharge planning, admission details, community services, drug availability may vary with local regions and for specific hospitals. A streamlined process to enable such variations to be accommodated by any general national clinical pathway is required. This sensitivity to local conditions is critical to the success of clinical pathways internationally and in Australia and should be a central consideration in the implementation of this part of the NHCAs. This localization process is also important in the development of transfer protocols for disadvantaged and at risk patients, which require local input. The proposed State/Territory Centres will enable efficient localization in each jurisdiction and enable both a regional and statewide capacity to effectively achieve this imperative with *economies of scale*. They could also facilitate the implementation and monitoring of such pathways and protocols across the health system, which is a component of the policy direction. Other ‘priority reform areas’ shown at Clause 30, includes:

### *Social inclusion and Indigenous Health*

- Expand and develop innovative programs for difficult to reach groups including indigenous men etc.

### *Sustainability*

- Increase capacity to train the workforce including regional Australia.
- Support workforce role redesign to ensure **most effective and efficient use** of available workforce.
- Engage in collaboration toward planning on capital infrastructure for health care services.

Two of the ‘policy directions’ for this area shown on page A16 are highly relevant:

- Build a collaborative approach to evidence based, **cost effective practices** with and across government and private sectors including investment decisions and clinical care
- Invest in research that promotes **evidence-based practice and innovation**.

The ‘periodic review’ at clause 31 will also be significantly impacted by the EBM initiative. It states that ‘policy reform direction will be reviewed to incorporate evaluations of existing interventions and provide the opportunity to respond to emerging evidence or challenges.

Key feedback from the National Seminars conducted by Antioch (Antioch, 2007) was that the **unique** feature of the EBM vision already implemented across six hospitals in Victoria, is the integration of **cost effectiveness evidence** with the processes along the lines of the methodology of Antioch, Jennings and Botti (2002) which uses that of the NHMRC (1999, 2000, 2001), and internationally (eg Drummond et al 2005, 2006; Antioch 2008, The Alfred, 1999). The process has attracted significant international and national interest and National Australian presentations in all states and territories sponsored by the AHA (2007, pg. 7) and by conferences in Europe. Most Australian States and Territories expressed

considerable interest in rolling out the methodology in their jurisdictions and this was a key recommendation arising from the National seminars. There was also a strong call to extend the EBM process across all health sectors. Industry feedback was that the integration of cost effectiveness evidence is a key challenge in the sector and resources are required to effectively do this work in line with the NHMRC methodologies as shown in NHMRC (2001), and Antioch et al (2002).

#### **(b) National Partnership Agreement on Hospital and Health Workforce Reform**

This National Partnership has a strong focus on responding to indigenous disadvantage at Clause 2, which is an emerging priority of the EBM vision. The proposed EBM vision and State/Territory Centres directly addresses the reform clauses at 3 (b) (c) (d) relating to workforce capability and supply, enhancing the provision of sub acute services and taking pressure off public hospitals. It can also address initiatives in clause 5 through addressing the impact of an aging population, rising chronic disease advancing technology and workforce shortage pressures.

The objectives at clause 12 highlighting improvements in hospital efficiency, workforce capability, ED functioning and the quality and volume of sub acute services can be addressed by the EBM vision and State/Territory Centres reinforced by published evidence of improvements in quality and efficiency across six Victorian public teaching hospitals over a 10 year period. The EBM vision included inpatient, ED and sub acute including the rehabilitation and psycho geriatric care and geriatric evaluation management at Caulfield hospital and the EDs of the hospitals across both networks. Regular feedback of performance results to the executive and clinical staff at various hospitals was essential to the success of the initiative along with the rollout of education programs across some campuses by the clinical leaders on finalized quality instruments.

The evidence supported the improved outcomes related to those specified in clause 13 (a) (b) (c). Changes in readmissions, reductions in adverse events and deaths measured improved health outcomes and patient experience. In addition, smooth patient transition between settings through assessment, referral and follow-up at key points in the patient health journey was achieved by development, implementation of clinical pathways, protocols and management plans using best practice (cost effectiveness) evidence and clinical guidelines. The hospital system became more efficient and sustainable providing the basis for micro economic reform and enabled successful adaptation to the pressures of increasing demand and rising health costs by achieving reduction in per patient costs and length of stay in areas addressed the EBM initiatives. All measures of changes in differences in efficiency and quality were casemix adjusted given comparisons were by DRG.

The EBM vision also facilitates meeting the objectives and outcomes of the Agreement in Clause 14 (b) (c) (d) by improving the productivity of multidisciplinary teams, improving sub acute inpatient and ED care.

With regard to the financial arrangements in Part 5 of the National Partnerships Agreement the funding stream 'Workforce enabler' is considered relevant to the EBM service redesign vision and State/Territory Centres. The Table at clause 22, entitled 'Maximum funding from Commonwealth to States 2008-09 to 2012-13' showing allocations for the period 2008-09 to 2012-13 indicates by way of footnote, that the Commonwealth will, in the first instance, provide funding to the National Health Workforce Agency which will, then distribute funds to the States and Territories and as specified at Schedule B of the Agreement.

Depending on the views of particular States and Territories, there might also be potential for funding the EBM initiative from the streams, 'sub acute care' and 'taking pressure off public hospitals'. At Schedule B on the "workforce enabler" initiatives, the relevant funding streams from the Commonwealth are at clause B8 (a) 'National Health Workforce Agency' and 'Workforce Redesign Funding'

The implementation Plan at Clause B5 (page 19) shows the relevant timelines as follows:

- Workforce redesign programs funded phase 2 (May 2009)
- National Agency work program agreed AHMAC (June 2009)
- National roll out of successful workforce reforms on phases 1 and 2 (March, September 2009, respectively).

The amounts allocated at Clause B8 are specified for both initiatives. Further, the role of the Commonwealth in funding both initiatives is specified in clause B12 (a) and (c) (Page 22).

Importantly, the funding approaches managed by the proposed Agency at Clause B5 (e) specifies that proposed workforce redesign strategies should improve the efficiency and effectiveness of the work force and will involve the agency designing and implementing strategies with and across all jurisdictions including 1 to 2 year pilots and reform projects, evaluation of workforce models to ensure quality, safety, efficiency and effectiveness and related training of health workers. Also, they should involve an examination of barriers to advise the Health Ministers on recommended changes along with the roll out

of successful projects nationally. There would be a need for the State-wide co-ordination to achieve economies of scale and the proposed State/Territory Centres would enable this to occur. Each State centre could link back to the National Health Workforce Agency and across States also.

The EBM vision and State/Territory Centres will also impact on Schedule C of the Agreements, relating to sub acute care. In particular, at Clauses C1, C5, C9 and C11, there is a key focus on new 'best practice' models of care and workforce to assist in increasing the volume and quality of such care in hospitals and the community.

**(c) The Intergovernmental Agreement of Federal Financial Relations (2009) Schedule E: National Policy and Reforms Objective**

The National Partnership principles specified at Clause E21 (a) (b) (c) and (d), can be addressed by the EBM vision and State/Territory Centres, given it has the imperative to significantly improve, through national reform, service delivery improvement where it has national good characteristics, where the benefits of involvement extend nationwide and where there is significant 'spillover' benefits that extend beyond the boundaries of a single state or territory. It can also have a strong impact on the Commonwealth's macro economic responsibilities and is sensitive to the current economic cycle. Emerging high priorities are for the EBM vision is to address the indigenous disadvantaged and social inclusion challenges. This imperative is an important current objective and expenditure priority of the Commonwealth Government.

**(d) National Indigenous Reform Agreement (NIRA) (Schedule F)**

Clause 4 of the NIRA provides important links to the other National Agreements and National Partnership Agreements across COAG that aim to close the gap in indigenous disadvantage. Clause 8 makes explicit reference to the 'health' building blocks and clause 10 (d) emphasizes that some National Partnership Agreements have an indigenous specific focus on indigenous health. Clause 11 focuses upon the achievement of outcomes via national agreements and national partnerships agreements as specified in schedule A of the NIRA. These are specified for health at page A 19 and include:

- Closing the gap in indigenous health outcomes National Partnership Agreement
- National Health care Agreement
- National Disability Service Agreement
- Hospital and Health Workforce Reform National Partnership Agreement
- Preventive Health Agreement.

The service delivery principles in Schedule B of the NIRA that are designed to ensure consistency across the development of National Agreements can be significantly impacted through the EBM vision and State/Territory Centres. In particular, there is great potential for the State/Territory Centres to impact on the priority principle at Clause B2 to meet *targets to close the gap*. These are further elaborated at clause B8 sections (a) and (b) regarding *children mortality rates and life expectancy*. The B-8 (a) targets are to close the 17 year life expectancy gap within a generation. The clause B-8 (b) targets are to halve the mortality rates for children under five within a decade.

The inter-disciplinary team approach in the EBM vision is sensitive to local circumstances, cultural and socio-economic requirements. Committee representations in the EBM teams, Clinical Teams and Steering Committees of the EBM vision (See Antioch et al, 2002, Antioch et al 2001 and Western Health (2006) can address the indigenous engagement principal at B9 (b) in the design and delivery of programs, which will be sustained in the health system in accordance with the *Sustainability Principle* at Clause B10 (a) (i) and (iii) given its strong emphasis on using evidence to develop and redesign programs, services and set priorities along with self management priority.

The demonstrated cost effectiveness of the EBM vision will enable achievement of Clause B10 (b) and especially (iv) and (vii) to ensure redesigned services to best use resources and ensure infrastructure is appropriate. Also relevant is Clause B 11 (a) and (c) which is designed to ensure the *Access Principle*. The *Integration Principle* is facilitated at clause B12 by identifying and addressing gaps and overlaps in the continuum of service delivery. Given the success in performance monitoring and feedback in the EBM vision, its implementation will facilitate meeting the requirements of clause B 13 – the *Accountability Principle*.

The EBM vision will facilitate achievement and implementation of the principle at Schedule C of the NIRA 'National Investment Principles in Remote Locations' especially clause C 1 (a), (b) (i) and (iii) where investment decisions should improve participation in education training and the market economy on a sustainable basis, promote personal responsibility and lead to greater equity in service and infrastructure standards comparable to non-indigenous communities in Australia.

The achievement of the COAG targets at Clause 16 (a) and (b) of the NIRA could also be facilitated and the links to the NHCA and NPs specified in schedule A.

The EBM vision may also assist with meeting the goals at Clause 22 of the NIRA relating to closing the life expectancy gaps within a generation and also halving the gap in mortality rates for indigenous children under 5 within a decade. The implementation of the EBM vision and State Centres could also consider the results of the required framework modeling specified in NIRA clauses 26 to 28 to drive their strategic and operational plans. These clauses state that in order to close the life expectancy gap, overall indigenous mortality would need to fall by at least 80% with life expectancy needing to increase by approximately one year per year over the target period. Likewise, the indigenous infant mortality rate needs to fall by an average of 0.4 per cent each year and child mortality (1-4 year old) rate would need to fall by an average of 4% per year.

The EBM vision and State/Territory Centres has highlighted the potential for strong links to the Guidelines and Economists Network International (GENI), which includes the World Bank on its Board, the active engagement with the WHO along with economists world wide<sup>8</sup>. These collaborators internationally can greatly assist in improving the health of developing and disadvantaged populations such as indigenous health with lessons learnt across developing countries in cost effective, best practice methods.

### (e) National Partnership Agreement on Preventive Health

The National Partnership Agreement on Preventive Health at Clauses 3 (b), 8 (e) and 10 (a) to (e) has a clear priority to support preventive programs and related policy with the enabling infrastructure for evidence based policy design and co-ordinate implementation. Clause 11 health workers, (b) has specific relevance given the focus on nationally agreed *guidelines*.

Further, clause 11 'Enabling Infrastructure' (b) specifies the need for a research fund to build on a evidence base and translational research and at (e) (ii) the creation of a national preventive agency to provide evidence based policy advice. The State/Territory Centres would greatly facilitate these.

The international linkages of the Centres via the GENI with the USA, Europe, UK, NZ, world bank and WHO via GENI will greatly facilitate the further development of a clearing house of cost effectiveness best practice evidence, which has great potential for further link to the work of NICS of the NHMRC. The goals link with the proposed national preventive agency.

### 3. National Health and Hospitals Reform Commission Interim Report (2008)

The Reform Commission (NHHRC, 2008 pg. 4) proposed a *National Health Promotion and Prevention Agency*, which would disseminate information on cost effectiveness and efficiency. This is similar to the National Preventive Agency in the National Partnership Agreement on Preventive Health. The EBM vision and State/Territory Centres is relevant, given it utilizes NHMRC and international methodologies on methods to grade and evaluate both cost effectiveness and clinical effectiveness evidence and also published gold standard Clinical Practice Guidelines, and to enable efficient and effective dissemination to stakeholders and its links to the GENI. The EBM vision effectively translates evidence into clinical practice with all sectors of the health industry.

The *Comprehensive Primary Health Care Centres* using agreed protocols with local hospitals for the transfer, assessment or admission (NHHRC, 2008, page 7) could benefit from implementation of the EBM vision and State/Territory Centres including the integration of cost effective, best practice into the electronic personal health record mentioned by the Commission. This could assist with the indigenous health challenges, facilitate the Reform commission's vision for access to primary care, chronic care and children, including the specific reference by Commission (NHHRC, 2008 page 9) to the need for a clear *pathway* for targeted care for children.

A key feature of the EBM vision and State/Territory Centres is the development and implementation of Clinical Practice Guidelines (CPGs), protocols, management plans and clinical pathways to rectify the overcrowding ED problems analyzed by the Reform Commission as being caused by capacity to admit people for inpatient care and where there is occupancy of 85% or more (NHHRC, 2008 pages 10). By reducing length of stay, increasing throughput and making better clinical

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<sup>8</sup> The Terms of Reference of GENI are included in this weblink: [http://www.echeroma2008.eu/pre-conference/guidelines\\_aua\\_1.php](http://www.echeroma2008.eu/pre-conference/guidelines_aua_1.php)

decisions in the ED, admission, inpatient care and discharge planning via the EBM vision, more patients are admitted and can potentially reduce overcrowding. Streamlining the care is central.

The organizational capacity of the *Aboriginal Community Controlled Health Services* and the *proposed National Aboriginal and Torres Strait Islander Health Authority* (NATSTHA) (NHHRC, 2008, page 14), could be greatly enhanced by the EBM vision and State/Territory Centres by supporting quality and access. The Reform Commission emphasizes that the NATSTHA is modeled on Department of Veterans Affairs' strong quality assurance mechanism (NHHRC, 2008, page 15).

The Reform Commission (NHHRC, 2009 page 20,21) has proposed options A B and C for changes to the governance arrangements for Australian health system. Irrespective of which option (if any) is implemented, the new reformed health system will be enhanced and rendered more cost effective through implementation of the EBM vision and State/Territory Centres and the international links for economic evaluation via GENI. The preference is for Option A. Options B and C would be unlikely to offer substantial cost effective improvements to the current health system based on international experience. They would be politically, financially, administratively and logistically very difficult to implement and would be unlikely to offer any real changes to the outcome of Australian health systems. They would need to be carefully considered in light of the Section 92 of the Australian Constitution.

The Reform Commission reinforces the need for 'targeted' investments in public hospitals to support reshaping of roles, functions, clinical process redesign and a 'reorientation towards community based care (NHHRC, 2008, page 24). This is directly relevant to the EBM vision and State/Territory Centres. The Commission highlights the need for clinical training infrastructure across all settings and the establishment of a National Clinical Education Training Agency (NHHRC, 2008, page 25). This is similar to the national health workforce Agency in the National Partnerships (COAG 2008) and the foregoing related discussion in that section.

The Reform Commission's final section emphasizes the need to integrate health and medical research into clinical practice (NHHRC, 2008, page 25) with the Commonwealth promoting this. The Commission's vision likes the NHMRC funding of 50 virtual research centers linking research and clinical practice and the NHMRC's proposed Centers of Excellence. The Commission states that the cost of adverse events and mistakes is \$2b per annum for the health system and argues that National Institute for Clinical Studies (NICS) should be strengthened to provide a 'clearing house' of evidence and educating the workforce (NHHRC, 2008, page 26). The EBM vision and State/Territory Centres could work synergistically with all of these initiatives, providing the state co-ordination function to enable within and between State interface and co-ordination for the various proposed NHMRC Centres of Excellence. The initiative would enable additional resources to assist with the broad imperatives of government.

The Reform Commission emphasizes the need to systematize access to the evidence base and capture data and reporting systems (NHHRC, page 25, 26). The EBM vision and State/Territory Centres could link to the work of the NCETA or the National Health Workforce Agency (NHWA) in the NP's which would advise on adequacy of proposed education in each region given health needs. The NHWA could purchase education placements from health service providers in partnership with universities and colleges and promote innovation in the workplace, the provision of modular competency – based program would be facilitated in the rural Australian it would report on the adequacy of accreditation (NHHRC, 2008, pg 25).

Importantly, the Reform Commission proposed a permanent independent national body to lead on quality and safety following on work of Australian Council on Safety and Quality in Health Care, which has limited funding. It should define, by the end of 2009 national indicators for safety and quality. A comparison among peers of patient outcomes is an effective lever for positive change. Local systems providing feedback to clinician's teams and organization in primary health services and private and public hospitals to build and enable continuous improvement. The Reform Commission proposes that all health services both public and private should report publicly on their research and quality improvement activities including reporting on actions arising from investigation of adverse events. Such reporting would be linked to ongoing accreditation and the longer term use of payments for quality (NHHRC, 2008 pg 26). The EBM vision and State/Territory Centres can facilitate the goals and enable co-ordination centre in each state and fits well into this framework.

The state level co-ordination by the State/Territory Centres will facilitate meeting these goals. The EBM vision and State/Territory Centres, which embrace all sectors of the health industry, will be cost effective and an EBM framework will enable infrastructure and links to the National Workforce Agency and NICS to deliver the imperatives. Inter-state synergies will also be enhanced.

## Recommendations

That you note the following recommendations

1. In line with the recommendations of the national seminars in all states and territories sponsored by the Australian Healthcare and Hospital Association (AHHA) and conducted by Antioch and key imperatives of Schedule F National Health Care Agreements and the National Partnerships – Hospital and Health Workforce Reforms, each State/Territory to consider implementing initiatives in the EBM vision/State/Territory Centres. Specification of any related pilot should address prevention, primary and community care, hospital and related care, patient experience, social inclusion, indigenous health, sustainability.
2. To enable the Social Policy and Reform Directions at Clause 30 of the NHCA on patient experience, including the policy direction to develop nationally agreed clinical pathways for key conditions (chronic and complex) and implement and monitor across the health system, the State/Territory Centres in recommendation 1 above should ensure the capacity for:
  - any generic, nationally agreed clinical pathway to be locally modified in a streamlined way to account and provide for local differences in hospital related network strategies and needs e.g. discharge planning, admission details, community services and drug availability etc which may vary with local regions and for specific hospitals.
  - local input in the development of transfer protocols. The proposed State/Territory Centres will enable efficient localization in each jurisdiction and enable both a regional and State-wide capacity to effectively achieve this imperative with *economies of scale*
3. Determine the possibility of funding the initiatives in (1) from the National Partnership Agreement on Hospital and Health Workforce Reform from
  - (a) The work force enabler. Linkage with the National Health Workforce Agency to be established. ‘Workforce redesign’ funding stream is relevant.
  - (b) Other potential funding streams are ‘sub acute care’ and ‘taking pressure of public hospitals’ streams.
4. Determine capacity to include initiatives in the
  - (a) Workforce redesign programs funded at phase 2 (May 2009)
  - (b) National agency work program to be agreed by AHMAC (June 2009)
5. Given funding requirements by the proposed National Agency at Clause B5(e), your jurisdiction’s pilots should ensure that the proposed redesign strategy should build in a capacity to evaluated and demonstrate:
  - (a) Capacity to roll out across jurisdictions
  - (b) Conceptualization into the 1 to 2-year pilots/reform projects.
  - (c) Quality, safety, efficiency and effectiveness
  - (d) Related training of health workers
  - (e) Examination of how barriers to success were effectively identified and systematically addresses.
6. To facilitate success of the pilots, ensure effective collaboration with the GENI, NHMRC and NICS and other key bodies outlined in the various relevant Schedules of the IGAs outlined in this paper.
7. Where a jurisdiction has a significant indigenous population, pilots for EBM vision to clearly specify at the outset the strategy to be developed to directly address the targets in National Indigenous Reform Agreements
  - (a) at Schedule B 8 (a) close the 17 years life expectancy gap within a generation and
  - (b) At Schedule B 8 (b) to halve the mortality rates for children under 5 within a decade.

Pilots should also address the indigenous engagement, sustainability, access, accountability etc and how the findings can be extrapolated to other states, especially those with a relatively high proportion of indigenous population.

8. Given proof of cost effectiveness of your jurisdiction's pilots, consider feasibility of national rollout of successful workforce reforms on phases 1 and 2 (March, September 2010, respectively).
9. Consideration be given to other sources of funding the EBM vision and State/Territory Centres such as:
  - 9.1 The Federal Government's Health and Hospitals Fund/ Infrastructure Australia.
  - 9.2 Additional available funding following consideration of the final report of the National Health and Hospitals Reform Commission's final report in July 2009.
  - 9.3 COAG consideration of the proposals from all officials on the specific proposals in relation to community, mental health, disability services and aged care in the first half of 2009 as part of the IGA program
  - 9.4 Programs announced in the Federal Budget during 12 May, 2009
  - 9.5 Any available funding from State/Territory governments remaining from the 2007-08 and 2008-09 budget allocations that have not been spent e.g. for quality assurance, infrastructure, and innovation funding streams.
  - 9.6 New funding announced in each State/Territory 2009-10 budgets.
10. Identify opportunities for economies of scale:
  - 10.1 Where dedicated State/Territory funding is not currently available specifically earmarked for the creation of such State/Territory Centres, there may be potential for the States/ Territories to allocate a small proportion of the funding streams for much larger new infrastructure or for the upgrade of existing infrastructure. The Centres could be accommodated within larger infrastructure arrangements.
  - 10.2 Infrastructure allocations for such State/Territory Centres could be justified with evidence of efficacy and effectiveness (from the Victorian experience) in the context of the 'stimulus spending' by the governments. Recent media reports relating to the Australian Financial Review Roundtable of Industry Figures are calling for imperatives to 'prioritize projects' and to back long term infrastructure *planning* as part of sweeping regulatory reforms.<sup>9</sup>

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8 May 2009

*This paper was provided to all Australian State and Territory governments and relevant Federal Government stakeholders in May 2009. The paper was submitted to the NHHRC by Dr Kathryn Antioch in June 2009 and included on the Reform Commission's website following agreement to do so by the Department of Prime Minister and Cabinet (PM&C) and the NT Health Minister. The work has been undertaken by Dr Antioch'*

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<sup>9</sup> Hepworth, A (2009) "Red Tape Risk to Projects" *The Australian Financial Review*, pgs 1, 7. 7 May 2009.

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