

National Health & Hospitals Reform Commission (NHHRC) Final Report: Summary

NHHRC's Exec Summary

The establishment of an independent National Health Promotion and Prevention Agency: The Agency should have a broad role to drive a fundamental paradigm shift in how Australians, and our health system, think and act about health and keeping well, including through better education, evidence and research.

We need to redesign health services around people, making sure that people can access the right care in the right setting.

Strengthened consumer engagement and voice:

The first lever is strengthened consumer engagement and voice. Consumer engagement is encouraged by:

- Building health literacy – for example, by including health literacy as a core element of the National Curriculum for schools;
- Fostering community participation – for example, through citizen juries on issues such as the allocation of scarce resources among competing priorities; and
- Empowering consumers to make fully informed decisions, for example, on choice of aged care services.

Taking responsibility:

Individual and collective action to build good health and wellbeing – by people, families, communities, health professionals, employers, health funders and governments.

Healthy Australia 2020 Goals:

- National Health Promotion and Prevention Agency – education, evidence and research to make prevention a high priority
- Greater personal responsibility supported to make healthy choices and decisions easier
- Health literacy – in National Curriculum for all schools; accessible high quality health information throughout life
- Person-controlled electronic health record
- Better information about creating healthy local communities – 'wellness footprints'
- Health promotion and wellness programs through the workplace and health insurers

Recommendations

Taking Responsibility: Individual and collective action to build good health and wellbeing –by people, families, communities, health professionals, employers, health funders and governments

Building good health and wellbeing into our communities and our lives¹

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 Health¹ 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.

We recommend that the National Health Promotion and Prevention Agency (NHP&PA) 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.

Recommendation #10: We support strategies that help people take greater personal responsibility for improving their health through policies that 'make healthy choices easy choices'. This includes individual and collective action to improve health by people, families, communities, health

¹ 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

professionals, health insurers, employers and governments. Further investigation and development of such strategies should form part of NHP&PA work on the Healthy Australia 2020 Goals, targeting cross portfolio and cross industry action.

Recommendation #11: We recommend that health literacy is included as a core element of the National Curriculum and that it is incorporated in national skills assessment. This should apply across primary and secondary schools.

Recommendation #12: We urge all relevant groups (including health services, health professionals, non-government organisations, media, private health insurers, food manufacturers and retailers, employers and governments) to provide access to evidence-based, consumer-friendly information that supports people in making healthy choices and in better understanding and making decisions about their use of health services.

Nurturing a healthy start:

Recommendation #22: We recommend an integrated strategy for the health system to nurture a healthy start to life for Australian children. The strategy has a focus on health promotion and prevention, early detection and intervention and management of risk, better access to primary health care, and better access to and coordination of health and other services for children with chronic or severe health or developmental concerns.

We recommend a strategy for a healthy start based on three building blocks:

- most importantly, a partnership with parents, supporting families – and extended families – in enhancing children’s health and wellbeing;
- a life course approach to understanding health needs at different stages of life, beginning with pre-conception, and covering the antenatal and early childhood period up to eight years of age. While the research shows that the first three years of life are particularly important for early development, we also note the importance of the period of the transition to primary school;

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.

Recommendation #91: Health and aged care spending is forecast to rise to 12.4 per cent of gross domestic product in 2032–33. We believe that:

- major reforms are needed to improve the outcomes from this spending and national productivity and to contain the upward pressure on health care costs; and
- improved health outcomes are vital in promoting a healthy economy through greater productivity and higher labour force participation; and evidence-based investment in strengthened primary health care services and prevention and health promotion to keep people healthy is required to help to contain future growth in spending.

Working for us: a sustainable health workforce for the future:

Recommendation #98: We recommend supporting our health workforce by:

- promoting a culture of mutual respect and patient focus of all health professions through shared values, management structures, compensation arrangements, shared educational experiences, and clinical governance processes that support team approaches to care;
- supporting effective communication across all parts of the health system;

Governments do not have a monopoly on health system reform, but they are uniquely able to influence the architecture of the health system and so create the imperative and support for others to act.

Actions taken by governments – such as new approaches to funding of health services – are often about allowing health professionals and health services to get on with the job of helping to create a better health system. Governments also have an important role in influencing how consumers can participate through investing in health literacy or strengthening consumer engagement mechanisms in the management of health services. But, of course, this works in both directions. To survive, governments must ultimately be responsive to the concerns of their constituents. This means that consumers, health services and other groups have an essential role in both identifying the case for change and creating the pressure on governments to take action on health system reform.

We want our Report to be a clarion *call* to action on health system reform by all parts of society, not just governments. As you read through the reform proposals, we want to encourage you to think about how *you* and *your* family, *your* community, *your* general practice, *your* hospital, *your* community health service, *your* workplace, *your* private health insurer, *your* university (and so on) can take actions to build a healthier future for all Australians.

Embedding prevention and early intervention:

Among health commentators, it is almost axiomatic to say that we have an excellent 'sickness' system, but not a system focused on keeping us healthy.

Our health system, like those of most other developed countries, provides generally excellent care when people are acutely ill (for example, experiencing a heart attack or suffering major injury in a car accident). But it is largely reactive, not pro-active, reflecting the evolution of health care treating essentially episodic periods of illness and infectious diseases that could not be predicted. As technology has progressed with developments like immunisation and availability of life saving drugs such as antibiotics, the preponderance of more chronic and complex lifestyle illness is more visible.

The availability of preventative interventions, the change in disease patterns, and the ability and support available to introduce and persist with prevention makes this aspect of care a 'no-brainer'. In general, in the past, health professionals waited for 'patients' to present themselves – the health sector does not actively go out seeking to encourage people to keep healthy. Now with a toe in the water, with activities such as preventative health care checks for the 44-49 year olds, for the 75 aged group, and Aboriginal and Torres Strait Islander people, as well as national cancer screening programs, the benefits are apparent. The challenge is to empower the further developments in the sector to succeed and be implemented.

There is not sufficient recognition of our own capacity to take action and improve our own health, supported by our families and communities. We heard about the vital importance of recognising and nurturing self-management to support people to take greater control in managing their health issues:

Self-management is what most people with long term conditions do – they manage their daily lives and cope with the effects of their condition as best they can, for the most part without any intervention from professionals.²

A cornerstone of reform should be a proactive model for health coaching and care management for citizens which supports self-management and drives a 'smarter patient' able to take increased accountability of their own health.³

The concept of a partnership highlights the need for health care professionals to understand and respect the role of the carer in achieving maximum health outcomes for their patient.⁴

These ideas, bubbling out of our submissions, speak to the reality that good health is not something that is simply 'done' to us through our interactions with the health system. We must be active participants in our own good health, working in partnership with our health professionals, our carers and families. But this has to occur within the context of our social and economic circumstances and the communities in which we live. The aim has to be to encourage and support everyone to achieve their maximum health potential, regardless of their age or whether they have a chronic illness or a disability.

Our views on prevention and early intervention begin with the valuable contribution of the World Health Organization's Commission on Social Determinants of Health.⁵ To make it easier for people to lead healthy lives, we support their call for governments to take action in addressing the social determinants of health. This includes improving our daily living conditions and the distribution of resources in society – our access to employment, education, housing, a clean environment, and so on. The more equal or fairer a society we have, the better health and social outcomes are for everyone in that society.⁶

Furthermore, governments have a powerful role to play in creating incentives and policies for a health promoting environment to help people make healthier choices. For example, in the tobacco control arena there is clear evidence of the efficacy of combining effective tax measures and social marketing campaigns. This combination represents perhaps the most successful approach to prevention

² Health Care Consumers Association of ACT (2008), Submission 89 to the National Health and Hospitals Reform Commission: First Round Submissions.

³ Accenture (2008), Submission 3 to the National Health and Hospitals Reform Commission: First Round Submissions.

⁴ Carers Australia (2008), Submission 55 to the National Health and Hospitals Reform Commission: First Round Submissions.

⁵ WHO Commission on Social Determinants of Health (2008) Closing the gap in a generation: Final report executive summary.

⁶ Recent cross-national comparisons have indicated that a constellation of health and social problems (including life expectancy, infant mortality, homicides, teenage births, imprisonment, obesity and mental illness) are worse where there are greater differences or inequalities in income within individual countries. In more equal societies, the improvements in health and social indicators apply to all groups, those on a low income and those on a high income. See: R Wilkinson and K Pickett (2009), The spirit level: why more equal societies always do better, (Allen Lane: London).

strategies.⁷ In addition, experts have proposed that harmful drinking could be tackled through managing both physical availability and pricing, in combination with social marketing and public education to address the appropriate cultural place of alcohol.⁸

But the real question for us is what actions can we put forward to embed prevention and early intervention into our health system? Our recommendations include a mix of 'top down' and 'bottom up' approaches.

A new Australian Health Promotion and Prevention Agency:

First, we are proposing the establishment of a National Health Promotion and Prevention Agency. This idea – which was also recommended by the National Preventative Health Taskforce – has already been partially picked up in the new National Partnership Agreement on Preventive Health⁹ and included in the Commonwealth Government's 2009–2010 Budget.¹⁰ This is a good start, but only a start. We want to be clear that our vision for this agency goes considerably further than what has been agreed to date.

The new National Health Promotion and Prevention Agency should have a broad strategic and tactical role in order to drive a fundamental paradigm shift in how we as Australians, and our health system, think and act about health. This means it must take on much more than 'social marketing' or advertising and education campaigns. It should:

- drive cross portfolio and cross industry sector actions to support a health promoting environment and society;
- have the major responsibility of commissioning, collecting and disseminating evidence on what are 'good buys' in prevention, including primary, secondary and tertiary prevention across health services and other settings. (This is needed to overcome the current 'chicken and egg' problem – we don't invest enough in prevention as we don't have a robust evidence base about the value of prevention, and we don't develop the evidence base as we don't invest in prevention);
- lead the development of new Healthy Australia Goals – where all Australians contribute to setting priorities about the measurement improvements we want to achieve in our health on a regular basis (see Section 5.3.3 for more information on our proposal for Healthy Australia Goals); and
- report to the whole Australian community about whether we are making progress on prevention.

⁷ M Wakefield et al (2008), 'Impact of tobacco control policies and mass media campaigns on monthly adult smoking prevalence', *American Journal of Public Health*, 98(8): 1443-1450.

⁸ National Preventative Health Taskforce (2008), *Australia: the healthiest country by 2020* (Commonwealth of Australia: Canberra).

⁹ All Australian governments signed up to the new agreement on preventive health in December 2008. The agreement is at: http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_preventive_health.pdf

¹⁰ Minister for Health and Ageing (12 May 2009), Media release: A new partnership – a new era in health and hospital reform, At: <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2009-hmedia02.htm?OpenDocument&yr=2009&mth=5>

This is a big job. And it needs many hands, not just governments, to get it right. We strongly believe that this new agency should be independent, with a diverse and expert board and the ability to engage with broad cross-sections of the community. Our model is fundamentally about engaging the whole community in prevention – individuals, the health sector, business, public health, researchers, sports, arts, the media, the finance sector, as well as governments.

Shifting the curve of health spending towards prevention:

We also need to start investing more in services and population-based interventions that are effective earlier in the course of a person's illness. There is good evidence that some preventive interventions can be an efficient use of our resources.¹¹ Like any spending, our investment in prevention should be both clinically effective and cost effective.

Two of our proposals are designed to ensure that we 'shift the curve' of our total health spending towards a greater investment in prevention. First, we have already explained that the new National Health Promotion and Prevention Agency has to take responsibility (with the aid of a dedicated and significant budget) for building the evidence base as to what works in prevention. This is essentially what the pharmaceutical industry now does through its research, development and testing of new pharmaceuticals. There is currently no similar 'sponsor' to invest in research on prevention and health promotion, which is why we are recommending that this vital role be undertaken by the new National Health Promotion and Prevention Agency.

But simply collecting the evidence on prevention is not enough. When we think of pharmaceuticals, for example, we have (in highly simplified form) three main steps: the research evidence is developed by the pharmaceutical industry; the Pharmaceutical Benefits Advisory Committee analyses and reviews the cost-effectiveness of 'new' pharmaceuticals against comparators; and a decision is made to fund cost-effective pharmaceuticals through the vehicle of the Pharmaceutical Benefits Scheme (with subsequent negotiation on the price payable by the Commonwealth Government).

Accordingly, we are recommending that we need to put prevention on the 'same footing' through establishing a common national approach to the evaluation of all health interventions. This would involve consistent evaluation of medical care, pharmaceuticals, prevention and population health interventions, medical devices and prostheses, allied health services and complementary medicine. To use an example, this might allow comparison of the relative efficacy of a medical intervention (gastric bypass), a pharmaceutical intervention (an anti-obesity drug), an allied health intervention (a structured program of exercises and diet management) and a population health intervention (a community walking program) in reducing obesity.

A common framework for evaluating health interventions is essential if we are to move away from the existing patchwork of health programs, each with their own funding silos.

¹¹ National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, at: www.nhhrc.org.au

Building prevention and early intervention into our health system:

Having established the principle that we need to fund effective prevention, we now outline some specific areas where we believe there is good evidence for reorienting our investment around prevention and early intervention.

A healthy start to life:

Acting early to keep our children healthy is one of the most powerful investments our society can make. The evidence is overwhelming. If we act early, we can prevent or reduce the magnitude of many disabilities, developmental delays, behavioural problems and physical and mental health conditions.¹² Providing a stimulating balance of quality antenatal and early childhood health services, community and education services is vital for all children. For the most disadvantaged families, a healthy start to life is equivalent to providing a lifeline to help lift children out of generational cycles of poverty and unhealthy environments and give them the best health and life opportunities.

Our recommendations for a healthy start involve ensuring that children get access to the right mix of *universal* and *targeted* services¹³, based on their age and their individual health and social needs. What this would look like is as follows:

Before conception: Universal services need to ensure that people who may become parents are as healthy as possible. Programs to reduce smoking, encourage safe alcohol consumption, tackle the use of harmful drugs and ensure responsible sexual behaviour are examples of important health promotion activities for potential parents. Targeted services would include ways to increase support to teenage girls at risk of pregnancy and young people at risk of sexually transmitted infections;

Before birth: All women would have access to universal primary health care services. These services would be effectively linked with specialist services (including obstetricians and midwives) to ensure that women have choice¹⁴ and continuity throughout their pregnancy and antenatal care. Targeted care would be offered for women with special needs or at risk, such as home visits for very young, first-time mothers;

Early childhood: We need to build upon the existing child and family health services (which are different in scope and comprehensiveness across individual states and territories). These services need to be universally available, effectively linked with other primary health services (such as GPs) and other social services (such as early education, welfare and child care) and retain a strong social health model. Our proposal is that all children from birth to eight years of age receive an evidence-based schedule of core contacts to allow for engagement with parents, advice and support, and health monitoring. (For example, this would include a

¹² J Shonkoff and S Meisels (2000), *Handbook of early childhood intervention* (Cambridge University Press: Cambridge).

¹³ Children with greater or more complex needs would get access to a targeted range of specialist services, in addition to everyone having access to a core package of services for a healthy start to life.

¹⁴ Following the completion of the Maternity Services Review, the Commonwealth Government has announced measures to improve choice and access to maternity services.

universal home visit within two weeks of giving birth and a six week full baby examination.) The provision of these services should ensure full continuity of care for mothers and their babies across all relevant health service professionals. Services provided by universal child and family health services would include:

- monitoring of child health, development and wellbeing;
- early identification of post-natal depression and support for healthy attachment;
- early identification of family risk and need;
- response to identified needs;
- health promotion (for example, support for breast feeding) and disease prevention; and
- support for parenting.

Special needs: Children with particular health or developmental issues (as identified by the universal child and family health services or the family's primary health care service) would be referred and eligible to get an enhanced package of care (for example, access to specialist services such as paediatricians, allied health, speech pathologists and other services required to manage disabilities or developmental delays). A care coordinator who is linked into a primary health care service would help support families of children with the most complex needs through coordinating and packaging the best range of services for these children and their families.

An important overarching principle is to make best use of all relevant services including child and family health services, child and family health nurses in schools, other primary health care services (such as GPs, midwives and nurse practitioners), and specialist services (including obstetricians, paediatricians, psychologists and speech pathologists). We discuss later (see Section 4.3.2) our recommendation for the Commonwealth Government to assume responsibility for the policy and public funding of primary health care services, including existing child and family health services that are funded and provided through state and local governments. We want to be clear that this proposed integration of state funded primary health care services and general practice should retain the important strengths of each service model. In the context of this discussion on a healthy start to life, this means ensuring that child and family health services continue to provide services under a social health or wellbeing model.

Health promotion in schools:

As children enter primary school, child and family health nurses working in schools provide the next important connection on the path to good health. Under our proposal, these 'school nurses' would have responsibility for providing the core services in the evidence-based schedule of contacts and health promotion activities for children from five to eight years.

We are recommending that all primary schools have access to a child and family health nurse for promoting and monitoring children's health, development and wellbeing. Universal access to 'school nurses' is an important component of our 'one health system' approach. Under the proposed integration of all publicly funded primary health care services, we would expect that there are effective protocols and good communication between child and family health nurses in schools and the family's GP or primary health care service. Both have an important role to play. Primary health

care services have responsibility for the continuing management of children's health, while 'school nurses' have a vital role in early identification of disease, health promotion, advice and education to children and their families. Child and family health nurses are also important to support families who might otherwise 'fall through the cracks'.

Moving on beyond our 'healthy start' recommendations, we support more generally the delivery of health promotion and early intervention activities in schools. We would like to see an integrated approach to health promotion, whether it relates to the physical health, mental health, oral health or sexual health of young people.

Children at schools are somewhat of a 'captive audience', so health promotion and early intervention programs provided through schools provide the opportunity to reach children who may not routinely use other health services. This is why, for example, we have recommended the national expansion of the pre-school and school dental programs. Health promotion and early intervention programs through schools can help instil the habits of a healthy life in our next generation.

Health promotion and good health at all ages and abilities:

While we have focused in the above discussion on our children and young people, we are strongly of the view that prevention, health promotion and early intervention should be incorporated for people of all ages and abilities, and across as many 'settings' as possible. We use the term 'settings' to refer to the different locations in which health promotion can take place – this includes schools, workplaces, community groups and sporting clubs, as well as in the course of our use of health services (sometimes called 'opportunistic prevention'). Hence, we have recommended, for example, that governments review any regulatory barriers to support the expanded provision of health promotion programs in different settings including by employers and private health insurers.

We want to stress the value of prevention, health promotion and early intervention regardless of people's age, health status or disability. It is important that everyone – including older people living in residential aged care or in the community, people with an intellectual disability, people living with a degenerative condition (such as multiple sclerosis) and people with other complex and chronic conditions – is given the opportunity to achieve their maximum health potential. We agree with the views articulated in one of our submissions:

Ensuring a healthy start to the third age will provide the most immediate benefits to individuals facing increasing age-related risks of many conditions, and also to the health care budget...To ensure that as many people as possible enter retirement in the best possible health, there is a need to develop more age-related initiatives within the broad preventative and health promotion strategies, and to supplement these initiatives with age-specific initiatives.¹⁵

We cannot describe every evidence-based early intervention or promotion program in this report. Moving towards greater provision of these services for people of all ages and abilities has to be a fundamental building block of reforming our health system.

¹⁵ Anna Howe (2008), Submission 222 to the National Health and Hospitals Reform Commission: First Round Submissions.

Connecting and integrating health and aged care services for people over their lives:

Currently our health system works reasonably well if people have acute or emergency problems that can be quickly resolved through one-off medical interventions. However, the needs of people living with chronic diseases, people with multiple complex health and social problems, and older, increasingly frail people are less well met. When we consider the balance and organisation of our health services, it is evident that our health system has not been designed around the needs of such people with more complex and long-term health problems.

Imagine if, when your car develops minor mechanical trouble, you had to go to one place for a diagnosis, another for parts, another for some repairs, another for some other repairs, with different bills from each provider – and with the complication of having to drive around in a defective vehicle to obtain all these parts. This is what would happen if your car was being treated in Australia’s antiquated health program structure. Program divisions are based on providers’ demarcations, rather than consumers’ needs. There is no consistency to the way the payments are structured and there is a confusing array of programs. This is detrimental for consumers and a significant obstacle to a person and family-centred health system.¹⁶

The people in most need are often the least well equipped to navigate their way around our incredibly complex health system.

The underlying premise of our recommendations in this section of our report is that we need to redesign health services around people, making sure that people can access the right care in the right setting. This must include a ‘full service menu’ of health and aged care services necessary to meet the needs of an ageing population and the rise of chronic disease. Redesign also involves ensuring that this complex array of services is well coordinated and integrated through more effective use of tools including standard assessment tools (to augment good clinical method), agreed communication systems with some built in protocols, shared understanding of care pathways and engaging the whole health care team, reforms to funding and embedding data systems for clinical and management purposes that promote better continuity of care and multidisciplinary collaboration across health care professionals.

Primary health care as the cornerstone of our future health system:

Our vision for a future health system involves revitalising and strengthening primary health care services. While Galileo was excommunicated for suggesting that the earth revolved around the sun, we don’t think it is too heretical to suggest that primary health care services should be the axis or pivot around which we seek to develop a person-centred health system. Indeed, we heard broad support throughout our consultations for expanding the role of primary health care services to take on this role.

¹⁶ CHOICE (2008), Submission 63 to the National Health and Hospitals Reform Commission: First Round Submissions.

Our recommendations to achieve this are in several parts.

Bringing together and integrating multidisciplinary primary health care services:

First, we want to make sure that we make best use of all primary health care services. We are recommending that **the Commonwealth Government take responsibility for the policy and public funding of primary health care services** that are currently funded by state, territory and local governments. This includes, for example, community health services, family and child health services, community nursing, allied health, and alcohol and drug treatment services. We believe that there needs to be significant investment in primary health care infrastructure. This must involve developing an integrated plan for the development and networking of all publicly funded primary health care services. To do this, we need to bring together general practice (funded by the Commonwealth Government) and primary health care services (currently funded by state and territory governments).

Investing and building comprehensive primary health care:

General practitioners are already the most visited health professional, with about 85 per cent of the population seeing a GP at least once a year.¹⁷ We want to build upon this and improve access to a more comprehensive and multidisciplinary range of primary health care and specialist services in the community. Our proposal for the establishment of Comprehensive Primary Health Care Centres and Services is about providing a 'one-stop shop' approach so that patients can get access to an expanded range of services (for example, pathology, imaging, community nursing, allied health), with better coordinated referrals and networks of services (including good linkages with specialists, mental health services, family and child health services, community care and aged care services) at more convenient times through extended opening hours.

We received considerable feedback and recognise that comprehensive primary health care is likely to include both 'physical' Centres and 'virtual' Services. Accordingly, we are proposing that the Commonwealth Government provide a mix of capital and establishment grants to promote the development of Comprehensive Primary Health Care Centres and Services. Existing primary health care service providers could combine and evolve into these larger groups, while the Commonwealth Government might also target the development of new Comprehensive Primary Health Care Centres and Services in areas where there is now limited access to these services.

Strengthened consumer engagement and voice:

From Day One, we have said that the first and most important principle guiding health reform is that it must be 'people and family-centred'. We use the term 'people' broadly and inclusively. People includes individuals, their families, carers, advocates and communities; and it extends to the many roles we have, whether as 'consumers', 'patients' or 'citizens'.

The principle of 'public voice and community engagement' is a separate, although obviously related, dimension of a people-centred health system. We believe that the health system of the future should be organised around the integral roles of consumer voice and choice, citizen engagement and community participation. This is about giving people real control and choice about whether, how, where and when they use health services, supported by access to evidence-based information that facilitates informed choices. It is also about ensuring that the experience and views of consumers and

¹⁷ Australian Institute of Health and Welfare (2008), Australia's health 2008, (Australian Institute of Health and Welfare: Canberra).

whole communities are incorporated into how we redesign and improve health services in the future.

Through our consultations and submissions, we heard strong support for strengthening consumer engagement and voice in our health system:

Actively creating space for the public to be heard not only allows a rich source of information on the patient journey and experience to be gathered, but is also a way for the system to recognise the value of the contributions that patients, carers and the community can make. The consumer voice is essential to full understanding about how to build a safe and quality health system.¹⁸

Consumers should not only be the focus of the health system, they should be at the centre of decision-making in health. Both at a policy level and an individual level, consumer experiences and preferences should help lead health system reforms, alongside the evidence base. The reality of shared responsibility requires not just declaring it but building consumer health literacy and access to quality information and advice.¹⁹

Improving health literacy:

However, we know that about 60 per cent of Australians are not able to effectively participate (exercise their 'choice' or 'voice') as they lack basic health literacy. That is, they lack the knowledge and skills to understand and use information about how to stay healthy or how to find their way around the health system. There is also clear evidence that lower health literacy can result in poor outcomes. People with poor health literacy have lower rates of screening for preventable health conditions, poorer experience in managing the health of their children, and difficulty in following instructions from their health care practitioner.²⁰

Accordingly, we have recommended that health literacy be included as a core element of the National Curriculum and incorporated in national skills assessment, applying across primary and secondary schools. Getting good information to our children is an effective way to boost our population's health literacy.

We have also proposed targeted approaches to improving health literacy in particular domains, such as mental health literacy. For too long, people with mental illness have been stigmatised. We are recommending a sustained national community awareness campaign to tackle this issue. More generally, we believe that it is vital that governments, private health insurers, health services, non-government organisations and the media all contribute to improving health literacy among the general population. Helping people to 'make healthy choices easy choices' has to apply at all ages and across all groups in our population.

¹⁸ Australian Commission on Safety and Quality in Health Care (2008), Submission 428 to the National Health and Hospitals Reform Commission: First Round Submissions.

¹⁹ National Prescribing Service (2008), Submission 431 to the National Health and Hospitals Reform Commission: First Round Submissions.

²⁰ Agency for Health care Research and Quality (2004), Literacy and health outcomes: Evidence report/Technology Assessment No. 87, at <http://www.ahrq.gov/downloads/pub/evidence/pdf/literacy/literacy.pdf>

Becoming 'extremists' on patient decision-making:

Donald Berwick, the American guru of quality in health care, recently challenged his fellow health practitioners to adopt some radical, and uncomfortable, ideas about what 'patient-centred' care should really mean.²¹ For example, he suggests that evidence-based medicine 'sometimes must take a back seat' if clinicians are truly to respect the wishes of patients. And that 'non-compliance' legitimately reflects the different values and priorities that individuals have in their lives, as well as highlighting the challenge of better information exchange between clinician and patient.

While we have moved a long way from the 'doctor knows best' philosophy typified by the 1960s Doctor Kildare television series, we are still some distance from a health system that genuinely lets patients 'call the shots'. Empowering consumers to make fully informed decisions is an important element of this shifting power balance between consumers and clinicians. For example, we recognise and support the increasing development of 'decision aids' that can be used to help patients make better informed decisions, incorporating their values and preferences about health treatment choices.²²

This summary document prepared by ASMI, September 2009 using information cut and pasted directly from the NHHRC Final Report.

²¹ D Berwick (2009), 'What 'patient-centred' should mean: Confessions of an extremist', Health Affairs, Web exclusive, published online, 19 May 2009. See also: P Chen (June 009) Letting the patient call the shots, New York Times, 4 June 2009, at: http://www.nytimes.com/2009/06/04/health/04chen.html?_r=3&ref=health

²² There has been considerable development in the United States of 'shared decision making' through the use of 'decision aids'. This approach is being used for what are termed 'preference-sensitive' decisions which involve patients making value-based judgments about the benefits and risk of particular treatment options to them as individuals. Examples might include decisions about treatment options for an enlarged benign prostate, lower back pain, osteoarthritis of the knee or non-invasive breast cancer. See: A O'Connor et al (2007), Toward the 'tipping point': Decision aids and informed choice, Health Affairs, 26(3): 716-725; 10:1377/hlthaff.26.3.716.