

# **AUSTRALIA SUMMARY REPORT**

**Based on the Study Tour of Australia and New Zealand organized by the Canadian College of Health Leaders (CCHL) and the Australasian College of Health Service Management (ACHSM), February 19, 2012 to March 2, 2012.**

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## EXECUTIVE SUMMARY

This report summarizes the observations and learning's from the Canadian participants in the Australia-New Zealand Study tour that was organized by the Canadian College of Health Leaders (CCHL) and the Australasian College of Health Services Management (ACHSN) between February 19 and March 2, 2012. This summary report focuses on the Australia component of the Study Tour and a separate report is available on the New Zealand component.

The study tour was well organized and Canadian participants had generous access to very senior leaders in the Australian health system. The presentations tended to cluster around five themes: the national health reform agenda; hospital sector; primary health care – Medicare locals; quality, safety, clinical effectiveness and health information; and private health insurance.

Overall conclusions from the study tour can be summed as follow:

- Although there are many similarities between the two countries, there are also many differences that we can learn from.*
- Although the systems are different (e.g. public/private distribution of funding for health service, and the Commonwealth versus state powers); the issues and priorities are the same – aging population, chronic disease management, integration of service, fiscal sustainability of the system, primary health care reform, health promotion etc.*
- E health continues to be an area for investment and planning -- in most health sectors Australia is still working with hybrid systems.*
- A key difference between Australia and Canada is the presence of a National Reform Agenda in Australia. While there are many Commonwealth – State challenges around implementation of that agenda, there is agreement on overall directions. The COAG process appears to have been very instrumental in creating this common direction and commitment.*
- There are many process redesign tools and experience in Australia, particularly in the State of Victoria that would be helpful in Canada.*
- Australia's new national system around health professional registration and regulation is something that Canada could learn from.*

- *While much has been accomplished in Canada around innovative approaches to move services to ambulatory settings, there appears to be even greater variability on this in Australia suggesting we still have more to achieve in this area in Canada.*
- *The wait list issues we are constantly struggling with in Canada are not nearly as serious in Australia. Related to this there is virtually no issue in Australia with patients in hospitals waiting for alternate levels of care – the ALC issue we are constantly dealing with in Canada.*
- *Australia is attempting to embed national quality and safety standards within accreditation processes. This is still at a very early stage of development but is an area Canada should watch and consider.*
- *Given that many provinces are moving towards Activity Based funding models, it will be instructive to carefully follow the Australian experience on this as they are implementing this on a national level.*
- *The public – private mix and the very prominent presence of a parallel private system in Australia is a marked area of contrast between the two countries. However, the relative merits of this approach are not consistently clear especially when one considers the same physicians work in both systems and there are high out of pocket costs for people using the private system even when they have private health insurance.*
- *While there are some key new developments in Australia around primary health care, especially with the new Medicare Locals, Canada’s approach to primary health care despite all its limitations appears to have some added strengths including the use of Nurse Practitioners and Inter Professional teams.*
- *On most measures of efficiency, quality and access the Australian system is comparable and in many cases better than Canada. Some insight into this can be gained from the tables in Appendix 2. However, at the overall country level in terms of resources expended on health expressed as the percentage of GNP, the numbers are not comparable as Australia does not include the vast majority of expenditures on aged care in health expenditure.*

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## 1. Preamble

This summary report attempts to capture the major learnings from the CCHL-ACHSM study tour to Australia during the period February 20 to February 24, 2012. The overview is from the perspective of the author who has been following the health care scene since 2004 when he participated in a similar study tour. This report focuses on areas that were given substantial discussion during the study tour and should not be considered an exhaustive list of the developments in Australia.

This report provides an overall summary of the Australian component of the study tour and includes *Insights from the Canadian Group and Lessons for Canada*. Two appendices contain additional information as follows:

**Appendix 1:** List of Australian presenters with their organizational affiliations. Access to the most of the presentations provided during the study tour are available on the website of the Canadian College of Health Leaders and they are numbered in the order they appear in Appendix; and

**Appendix 2:** Comparative Health System which compares several health system dimensions across Canada, Australia, New Zealand, England, Netherlands and Sweden.

The summary report is organized around six major themes that were pursued during the study tour:

- A. National Health Reform Agenda**
- B. Hospital Sector**
- C. Primary Health Care – Medicare Locals**
- D. Quality & Safety, Clinical Effectiveness, and Health Information**
- E. Private Health Insurance**

## 2. Background

Before delving into the major areas of this Summary Report it is important to recognize some key elements of the Australian system particularly where there are significant differences from Canada.

1. Role of Commonwealth Government – while Australia is a Federation like Canada, both countries have gone in quite different directions in terms of the powers of the national government with respect to health care. The BNA Act 1867 gave primary responsibility for health care to provinces as did the Constitution Act of 1901 in Australia. However, primarily since WWII Australia has taken a number of steps including some constitutional amendments to transfer powers from states to the Commonwealth Government, particularly with respect to medical services, pharmaceutical

2. Policy and aged care – more recently, the report of the National Hospital and Health Reform commission (NHHRC) in 2009 has led to a National Reform agenda. This stands in sharp contrast to the situation in Canada where provincial responsibility in health care has remained paramount and efforts to achieve a national reform agenda have lost momentum with no major attention since the 2003/2004 accords/plans. Another major difference in the federation structure between Canada and Australia is the much more constrained scope States have in revenue sources than provinces in Canada. States do not have the power to levy income taxes. So the fiscal imbalance is much more pronounced in Australia.
3. COAG - Council of Australian Governments – has become a key decision making structure in Australia and includes the Prime Minister and the Premiers of each of the 8 states (6) and territories (2). Unlike the Federal Provincial scene in Canada, COAG represents an ongoing structure with regular agreements. It is supported in the health arena by a Standing Council on Health (SCH) which is comprised of the Commonwealth Minister of Health and the Health Ministers from each of the States and Territories. The Standing Council in turn is supported by the Australian Health Ministers Advisory Committee (ARMAC) which consists of the Director Generals or equivalents from each of the States and Territories. (The DG position is the same as the provincial Deputy Minister of Health in the Canadian System).

### **3. Study Themes**

#### **A. The National Health Reform Agenda**

The National Reform agenda is based on the recommendations of the National Health and Hospital Reform Commission (NHHRC) which was established shortly after Kevin Rudd became Prime Minister in 2007. NHHRC, chaired by Dr. Christine Bennett, released its final report in July 2009. The report is generally regarded as a very comprehensive review of the Australian system with over 100 recommendations for change. The report drew considerable attention to the very fragmented nature of the Australian system caused by the division of responsibilities between Commonwealth and States/Territories (S/Ts). Whereas S/Ts have responsibility for hospital services, the Commonwealth has responsibility for pharmaceutical policy, the schedule for medical benefits (fee schedule for doctors) and large components of aged care. In addition the fragmentation is accentuated by the fiscal imbalance between S/Ts and the Commonwealth. S/Ts do not have power to levy income taxes. This power was transferred to the Commonwealth Government during WWII to allow the nation to secure resources for the war effort.

The recommendations of the NHHRC were largely embraced by the Rudd Government who initiated a series of actions to dramatically shift further power and fiscal responsibility for health care to the Commonwealth Government. However, since the

internal Labour party decision to replace Rudd with Julia Gillard, there have been some changes in the National reform agenda. The most notable changes has been a significant backing off of Commonwealth intrusion into S/T jurisdiction as S/Ts mounted significant resistance to losing control over their health systems. Since 2010 there has been a series of agreements through COAG, the most recent being in August 2011 to implement the National Reform Agenda.

Given the complex array of items on the National Reform Agenda, changes made in the successive COAG agreements, the leadership instability in the Governing Labour party at the Commonwealth level as well an impending election at the national level in 2013 where a change of government is a high probability, the National Reform Agenda can only be described as very fluid.

As of February 2012, the main focus of the National Reform Agenda is in seven areas with three other major initiatives - Health Workforce Reform, Health Professional Regulation Reform, and Preventive Health Reforms continuing to have high priority although they preceded the National Reform Agenda.

- 1. Financial Commitment** - the Commonwealth has made a commitment to increase its funding for hospital services by \$16.4 billion between 2014/15 and 2019/20. The goal is to change the Commonwealth share of hospital funding from its current 40% level to closer to 60%. A key strategy in effecting this increase is fund a higher share of growth in hospital efficient services, starting with 45% target in 2017 and rising to 50% in 2019. In addition the Commonwealth has committed \$7.8 billion over five years to support other elements of health reform, including incremental funding for the new Medicare Locals and new contributions in Aged Care. The Commonwealth has also backed off an earlier plan to claw back part of the GST revenue that now goes to the S/Ts.
- 2. Primary Health Care** - there are numerous strategies to access to primary care services, including the establishment of Medicare Locals (discussed below), creating 60 GP Super Clinics, new approaches in the treatment and management of diabetes, an after hours GP helpline, and funding infrastructure for 425 primary care infrastructure upgrades, including services for Aboriginal Medical Services.
- 3. Local Hospital Networks** - in return for the infusion of new money by the Commonwealth, S/Ts will implement Local Hospital Networks, essentially a governance structure for hospitals in a given area with appointed Boards. This is a significant change for all S/Ts except the State of Victoria. In all other states governing hospital board structures do not generally exist. The model being introduced appears to be based on the Victoria model which has had a system of hospital boards since the 1930s.

4. **Activity Based Hospital Funding** - discussed below under the Hospital sector.
5. **National Health Performance Authority (NHPA)** - is being established to produce hospital performance reports for both public and private hospitals. In addition NHPA will produce Healthy Community Reports on primary care. An independent board has just been established with one of the members, Dr. Diane Watson, serving as the interim Chair. Dr. Watson is a Canadian who came to Australia within the past two years to head up the Bureau of Health Information in the state of New South Wales. An element of the reporting will be the new National Standards that were agreed to in 2010 at the COAG.
6. **Commission on Quality and Safety** - discussed below under Quality, Safety and Clinical Effectiveness.
7. **Aged Care** - the Commonwealth will assume responsibility for Aged under a national system. All care for persons over 65 will become the responsibility of the Commonwealth Government by 2015. The intent is to increase options for community living. There is an excess of residential care beds in many places in Australia with overall occupancy rates in these facilities at 93%. The plan is to move to a subsidy approach with three tiers. Individuals will have access to these funds to purchase care of their choice. Part of the subsidy scheme is intended to involve a new approach to release equity in homes to the aged care provider on an interim basis.

**The following three initiatives have been reinforced by the National Health Reform Agenda although their origins preceded the NHHRC.**

8. **Health Workforce Reform** - COAG committed to the National Partnership Agreement on Hospital and Health Workforce reform in 2008 with a commitment to \$1.1 billion over four years. Health Workforce Australia (HWA) was established by a Commonwealth statute in July 2009 to lead the implementation of the agreement. HWA reports to the Standing Committee on Health. HWA was established in a policy context to achieve self sufficiency in health workforce supply. A key program area is generating information and analysis: supply and demand estimates for health professionals, including physicians by speciality, the projection of training places to match demand, and the development of alternate scenarios considering different productivity, retention, and working hour assumptions. Other key program areas include innovation & reform projects focused on workforce categories; clinical training reform including increased student enrolment, increased clinical training capacity, clinical supervision, simulated learning; and integrated clinical training networks to align with other health reform initiatives (e.g. Medicare locals); and international health professionals including attraction, marketing, ethical recruitment and retention. (Appendix)

**9. Health Professional Regulation Reform** - the recommendation for a national approach came from the Productivity Commission report in 2006 which was moved forward with a COAG agreement in 2008. The reform disestablished the S/T processes for registration health professionals which included 85 professional boards and 38 regulatory agencies. These were replaced by a single national legislative framework. To do this a piece of Legislation had to be passed in each S/T with corresponding legislative changes at the Commonwealth level. The new process came into effect as of July 2010 which includes the registration of 580,000 practitioners. (Appendix)

**10. Preventive Health Reforms** - in 2007 preventive health was identified as a key element for the national reform agenda resulting in a landmark COAG agreement in 2008 to create the National Partnership Agreement on Preventive Health. This was reinforced in the NHHCR in 2009 and led to the creation of the Australian National Preventive Health Agency (ANPHA) Act in November 2010 and the establishment of the agency in January 2011. The intent is to build on Australian successes in tobacco control, road safety and sunscreen.

Priorities for ANPHA include obesity, tobacco and alcohol. (Appendix)

### ***Insights from the Canadian Group***

- Many of the challenges are very similar to those in Canada (e.g. PHC reform, sustainability of the system, health human resources).*
- Australia appears to have more consensus in moving forward on reform agenda with the establishment of COAG (Council of AU governments comprised of prime minister and State Premiers) resulting in a number of key initiatives moving forward across the country rather than having different reform agendas across the country.*
- Health care agenda driven primarily by commonwealth since they are primary funders given their taxation powers.*
- Much more involvement of the Commonwealth government than is currently the case with the Federal Government in Canada.*
- The power of the Commonwealth Government creates tension in terms of setting national agenda and standards, performance metrics and funding levels. This leaves less autonomy at state level to set direction to respond to patient and population needs.*
- The Australia system does allow more opportunity for national benchmarking and public reporting on outcome and performance metrics at a national level and this will start within the next year.*

- The work done to date by the Bureau of Information in New South Wales on public reporting is excellent and is intended to shape the work of the new National Health Performance Authority. It is noteworthy that the Bureau is headed by a Canadian, Dr. Diane Watson.*
- Reform on health workforce and Health profession regulation is very impressive.*
- Given Australia's dependence on international professionals a focus on global mobility makes sense.*

### ***Lessons for Canada***

- Australia's approach to consensus building at the Commonwealth – State levels demonstrates that achieving consensus at senior F/P/T levels on health reform directions would move these forward more quickly.*
- Australia has been successful in developing and implementing a national provider registry (professional registration); Canada can learn from their success.*
- Australia's work on Preventative health reform at the national level should be looked at for Canada.*
- Australia's ability to integrate health profession boards into a national system and having one national standard for practice and regulation is impressive. This also allows for consistent national data through single registration.*

### **B. Hospital Sector**

A few comparative statistics on the hospital sector are appropriate to provide context to the following section:

|  | <b>Can</b> | <b>Aus</b> | <b>NZ</b> |
|--|------------|------------|-----------|
| Acute Hospital Beds/1000                 | 3.8        | 4.0        | NA        |
| Acute Hospital Discharges/1000           | 84*        | 162.4      | 141.6     |
| Average Length of Stay – Acute Care-Days | 7.7        | 6.0        | 8.7       |
| Physician Consultations/1000             | 5.5        | 6.4        | 4.3       |

Source: OECD Health Data 2011 and Health at a Glance, 2011

\* excludes babies born in hospitals

The biggest difference between Canada and Australia is the significant presence of private hospitals in Australia. In total, there are about 750 public hospitals and 573 private hospitals in Australia. Private hospitals account for 32% of the beds and 40% of the admissions representing 31% of hospital days. (There are 1,326 hospitals in Australia of which 290 are private). In the past decade Private hospitals have expanded their scope of activity and currently private hospitals account for 40% of total hospital separations. The proportion of hospital activity done in private hospitals is as follows:

|                                     |     |
|-------------------------------------|-----|
| Mental Health same day treatment    | 81% |
| Other Knee procedures               | 78% |
| Middle Ear infection                | 71% |
| Lens procedures                     | 70% |
| Other Major joint replacements      | 65% |
| Cancer Therapy – Chemotherapy       | 60% |
| Major procedure – breast malignancy | 56% |
| Hip replacements                    | 56% |

Overall 45-50% of surgical procedures are done in private hospitals. However, 80% of emergency care is still provided in public hospitals. So the dominant pattern of private hospitals handling scheduled elective care continues. There is also a very clear pattern of private hospitals being collocated with public hospitals thereby making it much easier for physicians to work in both systems.

As noted above, one of the key national health agenda reforms is to increase the Commonwealth share of hospital funding. This will be done through the introduction of an Activity Based Funding (ABF) funding model. The Independent Hospital Pricing Authority (IHPA) was established in December 2011 by Commonwealth Statute with an independent board with 9 members appointed by Commonwealth (1) and S/Ts (8). Commonwealth appoints the Chair and S/Ts appoint vice chair, but Commonwealth cannot interfere with IHPA decisions. Dr. Tony Sherban has been appointed as acting CEO.

In developing ABF the first task of IHPA is to define hospital services. Then a national efficient price will be determined for each service and the first iteration of these prices are to issue by March 31, 2012. The actual funding will be provided by a new separate agency, the Hospital Funding Agency, which as of February 2012 has not been established. Yet the commitment remains the new ABF model will be in place starting July 1, 2012. A key issue at this point is how they funding will be flowed. While the intent is for the funding hospital to do directly to the hospitals, this seems to be somewhat in question with the alternative being to flow funds to the S/Ts who in turn will fund hospitals. A key objective of the new funding model is to achieve transparency in the flow of funding to hospitals from the Commonwealth and S/Ts. The approach is to have hospital funds from both the Commonwealth using the ABF formula and funds from the S/Ts to create a funding pool. S/Ts have been given assurance that their funding will not be diverted outside their jurisdiction. There is no restriction on S/Ts on how they might supplement the ABF other than their fiscal capacity. The new funding model poses

particular challenges for the State of Victoria as it has had a fairly complex case mix funding model in place for years. So the attempt to create one price for across Australia, there is a fear that the new funding model will lose some of the sensitivity in the current model.

Even with the introduction of ABF there is recognition that the model will not be applied to smaller rural and regional centres who will continue to be block funded. Again IHPA will determine the model for block funding, but S/Ts will still be able to supplement.

Alongside the development of the new ABF model, there is also a National Agreement on Improving Hospital Services that sets out performance targets for elective surgery, emergency departments as well as funding for increased sub acute capacity. The agreement incorporates the recommendations of a Panel of physicians, health professionals and administrators established by COAG. Some of the key targets are: four hour access for patients in emergency departments; two new elective surgery targets while dropping the National Access Guarantee that was previously being discussed.

While ABF in theory has much support, there are numerous concerns about how the model is being developed and the timelines for implementation. The State of Victoria has particular concerns as it has had an ABF system for several years.

### ***Insights from the Canadian Group***

- Concern about sustainability of hospital budget has driven to new model of hospital funding (ABF – activity based funding).*
- Implementation of ABF is occurring at very fast pace; ambitious timelines.*
- Complex payment scheme for physicians working in hospitals whereby state pays for physicians in public hospitals and commonwealth pays for physician services in private hospital.*
- Moving to an ABF with the new Independent Hospital Pricing Authority (IHPA) is a good initiative at national level but it appears the implementation planning is not fully worked through. Target date for implementation seems aggressive with a fully formed plan not yet in place (how funding will flow; how to address differences in and defining of hospital services, e.g. the role of teaching hospitals).*
- Tension evident around between commonwealth and states around the implementation of ABF.*
- Having a national agreement on performance indicators for hospital services and reporting this publicly is in line with what Canada is doing.*
- The dynamics and complexity of managing in a public and private system is evident in terms of access and wait time for scheduled procedures. Wait time for*

*elective procedures are longer in the public system in part because physicians work across both systems. Differential access for the population is an issue in Australia.*

- Application of lean methodology evident in the hospital sector with priority emphasis on this work to improve, movement of patients through the system in the most cost effective and efficient manner while ensuring high quality and safety.*
- Surprised by the lack of clarity and specificity on the plan to roll out Activity Based Funding by the Commonwealth Government in July. To an outsider all levels seem unprepared for this.*

### ***Lessons from Canada***

- For provinces moving towards ABF, it will be important to follow up on experience in Australia's experience with ABF implementation and learn from their experience. It will be interesting to see if it will result in driving inappropriate volumes of procedures, or can work with the rest of the system for more integrated care and shifting of care from hospital to the community setting.*
- With the implementation of ABF, it is important to develop accountability and performance framework with defined set of goals/indicators to provide appropriate reform agenda.*
- Hospitals have embraced Lean methodologies to increase efficiencies; opportunities for Canada to learn from their experience in improving efficiencies and improvement in clinical programs; need to ensure any improvements are self-sustaining over the long term.*
- Many hospitals focus on integration of services; quality and safety and cost efficiency through application of Lean methodology and clinical redesign as we are doing in Canada. So there is an opportunity to share practices and tools.*
- Our focused work in Canada on wait time and capacity building has allowed us to make great gains in terms of access to services within the public system; although the establishment of ambulatory centers that can focus on certain procedures and develop excellence at lower cost but comparable or better quality, appears to more developed in Australia and may be something we should place greater emphasis on in Canada within the public envelope.*
- The issue of Alternate Level of Care (ALC) pressures is not as pronounced as in Canada. They actually do not articulate this as an issue. Shifting care to the community and capacity of residential beds perhaps is greater although still not clear why they do not have this issue and we could learn more from them on this.*

### **C. Primary Health Care - Medicare Locals**

Medicare Locals are a key element of the National Reform Agenda which is a new model for primary health care to be achieved through the establishment of Medicare Locals (MLs). MLs are to be broad based organizations, covering a geographic area, to coordinate the full range of primary health care services and to develop solutions on identified gaps so there is increased access and continuity in primary health care. The geographical boundaries of the MLs have been prescribed.

MLs will build on the efforts of the Divisions of General Practice, an initiative that has been in place in since the 1990s. However, it is expected that the 112 GP Divisions will be replaced by 62 MLs serving populations from 40K to 900K with the average being in the 300Kto 400K range. Effective July 2012 funding from the Commonwealth to GP Divisions will cease.

While there are many questions and much scepticism about MLs, the initiative represents the first time responsibility for PHC has been vested in one regional body. MLs will have responsibility to retain GP engagement but also to develop a much broader and interdisciplinary approach that organizes/brokers services based on health needs of their population. To achieve this will require strong partnerships among a wide variety of organizations. There is also an expectation that MLs will develop closer links with Local Hospital Networks.

Implementation of MLs only began in mid 2011 and this time they are still very early in their formation. There is a wide variety of expectations for MLs and each ML is developing an implementation strategy to suit its particular situation. Not only will there be a consolidation of GP serviced previously provided by the GP Divisions as noted above, but as well numerous services previously under State jurisdiction are being transferred to MLs where the funding comes from the Commonwealth. This includes cancer screening, immunization, specialist mental health services, maternal and child health services, health promotion programs, drug and alcohol treatment services, and community palliative care albeit some exceptions have be worked out with the S/Ts. This vision is very dependent on strong partnerships and achievement of the many expectations will require MLs to:

- Develop a Population Health Planning capacity
- Bring organizational cultures together
- Develop a procurement capacity
- Maintain service delivery
- Retain general practice engagement

The expectation that MLs will begin to coordinate their work with Local Hospital Districts will be very challenging given the divided jurisdiction between S/Ts that have primary responsibility for hospitals and the Commonwealth will have prime

responsibility for MLs. In addition in the State of Victoria there are no coterminous boundaries between the local hospital districts and MLs.

The population of MLs ranges from 250K to 500K but some rural areas will be much lower. There are numerous current arrangements in place within S/Ts to coordinate existing activities. The Primary Care Partnerships (PCPs) in Victoria have been in place for over ten years to help coordinate activities to reduce pressure on hospitals. Now this work will largely be taken over by MLs. Victoria has decided not to dismantle its PCPs until they are convinced that MLs will actually assume this role.

MLs across Australia are being rolled out in three different tranches with the first group initiated in mid 2011, a second in early 2013 and the last group in late 2013. The Commonwealth has committed \$400 million to support the establishment of MLs. In theory the Population health planning role should be greatly advanced by the introduction of the E Health record scheduled for July 1, 2012 but it is very unlikely that this target date will be met in any form.

The ability to initiate a successful implementation strategy for MLs is largely tied to the history of the GP practices in their boundaries. MLs that have a limited number of GP Divisions and especially those MLs that had progressive Divisions are in a much better starting position. A clear example of this was the Barwon ML in the state of Victoria. This ML is about 1 hour from Melbourne, serves a population of 280K and had only one GP Division that had many progressive initiatives and good relationships with other groups. The CEO of the GP Division has now become the CEO of the ML. With this history, the ML has achieved much in its first six months including:

- High GP engagement
- High degree of allied health involvement
- One electronic system nearly in place
- Medications to hospital patients recorded on system
- A chronic eHealth record
- New initiatives in mental health
- Project on advanced care directives

### ***Insights from Canadian Group***

- Focus of reforms in primary care has been primarily on physicians (GPs), and not inclusive of other health professions.*
- Unclear how Medicare Locals will collaborate (if at all) with Local Hospital Networks to provide care to local communities.*
- Focus on Primary care reform commendable and similar to Canada although the strategy for Medical Care Locals and GP Super Clinics does not seem to be crystallized in a coherent manner.*

- *The focus on primary care reform is aligned with many other countries including Canada as a key priority for reform. The intent to move to Medicare Locals that have accountability for the full range of primary health care services that increases access and coordination of services is a positive step, although organization and planning around this is still variable. The goals of better managing chronic conditions, focusing on prevention, reducing pressure on hospitals and improving performance and accountability are congruent with the work Canada. The key to success is to continually engage GPs and build relationships between them and the other key players in the system.*
- *There appears to be much less emphasis on the development and utilization of Nurse Practitioners (NPs) as part of the Primary Health Care Strategy in Australia. Given the evidence that NPs can play a major role, Australia could learn from Canada's experience in this respect.*

### ***Lessons for Canada***

- *To be successful in PHC reform, positive pre-existing relationships with medical community is key.*
- *Our focus and funding support on integrating NPs within the primary care model is strength in Canada. As well, the development of an inter-professional model within the primary care practices appears to be an area where some greater strides with some good outcome have been made in Canada as compared to Australia.*

### **D. Quality, Safety, Clinical Effectiveness, Health Information**

There are a number of initiatives at both the national and S/T levels directed at new initiatives to increase performance related to quality, safety and clinical effectiveness. Underlying these initiatives are also several strategies to improve the availability of health information.

At the national level there is a new entity the ***Australian Commission on Safety and Quality in Healthcare (ACSQHC)***. An Advisory Committee to Health Ministers jointly funded by the Commonwealth and S/Ts was established in 2005 to lead quality & safety, advocate for Q&S, recommend national data sets, and provide strategic advice to Health Ministers and to recommend nationally agreed standards. In 2011, as part of the National Reform Agenda, this was elevated to a national authority with the added roles of formulating standards and guidelines relating Q & S and monitoring the impact of these.

The ASQHC is seen as one of three new national bodies critical to achieving the National Reform Agenda with the other two being the National Performance Authority (NHPA) and, the Independent Hospital Pricing Authority (HPA) discussed above.

ASQHC works with Clinical Excellence Commission (CEC) in NSW and with quality initiatives in Queensland and Victoria. CEC is the leader and ASQHC recognizes the limits of what a national commission can do as they do not have the direct links to health care delivery and the clinicians. Consequently most of the work of ASQHC has been on broader organizational and policy issues. More recently there has been more acceptance of having ASQHC to assist with implementation as well.

ASQHC has no single plan for Q & S in Australia but its initial focus has been on safety. It has a broad mandate but most of focus has been on hospitals. With respect to Aged care, the Commonwealth Government itself has taken on role on the primary role for quality improvement. There appears to be some reluctance to have an external agency commenting on an area that is under direct jurisdiction of the Commonwealth.

ASQHC is not a regulator. Even on the Q & S agenda it has difficulty reaching out to all sectors. In particular there is concern about Primary Care and there is hope that the Medicare Locals (MLs) might provide a new opportunity to focus on Q & S. MLs are to have a relationship with ASQHC.

An early piece of work of ASQHC has been the development of a set of National standards which are now being incorporated into the accreditation requirements. Under the National Health Reform initiatives all hospitals and MLs will need to be accredited the 10 national standards in Q & S are broader than hospitals and are to apply to health services generally. Work is also underway to get agreement on indicators for primary care.

As noted above, the *Clinical Excellence Commission (CEC)* in NSW has become the preeminent body. Its focus on clinical effectiveness is centered on the appropriateness of care. CEC was established in 2004 and places its emphasis on quality versus safety. While often two sides of same coin, CEC believes safety is concerned more with what went wrong and quality is more centered on improvement. CEC uses a combined approach of Root Cause Analysis (RCA) to identify system problems and then reflective practice to interpret the analysis. CEC has developed several programs such as “Between the Flags” has been labelled using the popular “Surf Lifesaving” program in Australia to prevent drowning. The key concept in this program is not just to recognize impending clinical care issues, but also to have a systematic response to conditions to prevent further deterioration in patients.

CEC places a major emphasis on dealing with the human factor noting clinical performance is greatly affected by a number of human and organizational processes including the nature of hierarchical systems, communication patterns and tendencies to shift blame. CEC is working with hospitals on a voluntary basis and getting increasing buy in to its programs and processes. CEC has built this level of engagement by direct links with clinicians who are involved extensively in the reflective practice approaches.

Given the move towards Local Hospital Districts each with their own board, as per the National Reform Agenda, CEC has some concerns that its relationship with clinicians

might be jeopardized. However, on balance CEC is hopeful that the engagement it already has from clinicians will out ensure the linkage continues under the new model.

While ASQHC provides a focus on Q & S at the national level and CEC has a focus at the state level, there are many institutional level initiatives as well in Q & S.

The *Centre for Clinical Effectiveness (CCE)* at Southern Health in Melbourne in the State of Victoria appears to have a unique role. Southern Health is the largest health service in Victoria – primary, secondary, quaternary. It provides an integrated service with more than 40 sites and 13,000 staff. It has a long standing relationship with Monash University and is presently developing a new Academic Health Centre model.

The CCE was established in 1998. It has some base funding from Southern Health but also relies heavily on commissions both internal to Southern Health and external with the providers in the state, other S/Ts and with the Commonwealth. The model of Knowledge Translation it has developed is unique and has been extensively influenced by work in Canada. The focus of CCE's work is researching methods to get evidence into practice or the implementation of research. The Centre's director, Dr. Claire Harris has spent time in Canada and working with Jeremy Grimshaw, U of Ottawa, John Lavis, McMaster and others. CCE has three main goals:

1. To support organizations and individuals to achieve clinical effectiveness;
2. To provide education and training in skills for clinical effectiveness;
3. To undertake research to understand and enhance processes of clinical effectiveness.

In 2007 Southern Health introduced a new decision process for the introduction of new technology using CCE as key supporting unit. This has become known as part of Southern Health's SHARE program – "sustainability in health care by using resources effectively". An example of this application is the reduction in the range of drugs within the same class that are used. Hospital has reduced the number of ACE Inhibitors it uses from 8 to 2.

Related to the area of Q & S is the renewed emphasis on Accreditation in Australia. While the *Australian Council of Healthcare Standards (ACHS)* has been in place since 1974, accreditation has not been mandatory. This will change effective January 2013 as part of the National Reform agenda which will now make accreditation mandatory. As noted above, accreditation will need to incorporate the 10 National standards as developed by ASQHC.

While ACHS has about 85% of the accreditation work in Australia, under the new mandatory system, organizations will have a choice of accrediting agencies with a total of 14 bodies currently certified. They must be certified with ASQHC. ACHS is confident it will maintain its market share given its deep roots with the Australian system. There is some speculation that the other 13 agencies, all ISO certified, may undergo a process of mergers to reduce that number.

Another area of extensive discussion on the study tour that relates to Q & S is the development of better health information. The ***Australian Institute of Health and Welfare (AIHW)***, established in 1987 has an independent board with representatives from the Commonwealth, the S/Ts and some independent members. While AIHW reports to the Commonwealth it sees its role as serving all Australia. AIHW has a budget of \$50 million of which only \$17 million is an operational budget from Governments. The other \$33 million is comprised of work for specific services. AIHW is seen as independent and objective. It often puts out reports in areas where Government would find difficult to report on – e.g. where they run programs. AIHW has a broader role than CIHI in Canada as they are also concerned with social services and housing. However, the depth of data collection in the health system is not nearly as deep as is the case with CIHI. AIHW does not have any clinical data. In that the National Reform agenda has put increased emphasis on transparency of information and accountability, AIHW is expected to have an increased role.

The study group also has an opportunity to meet with Dr. Jeffrey Braithwaite, Professor and Director of the ***Australian Institute for Health Innovation (AIHI)*** at the University of New South Wales. AIHI consists of four research centres: Centre for Health Informatics, Centre for Health Services Research, Centre for Health Systems and Safety Research, and the Centre for Clinical Governance. The Centre has a very active and rapidly growing research agenda in several areas including clinical governance, quality and patient safety, interprofessional models of care, the use of networks in health services and practice variation. A current study on care patterns to be released shortly has taken the methodology from a recent US study (McGlynn/Rand) which showed on 46-56% of recommended care was being provided to review the situation in two states with a sample patient population of 1,200 matched to the US study. Another current study has looked in depth at the extent interprofessional collaboration in care provision over a four year period and the results showed no improvement.

### ***Insights from Canadian Group***

- There are many successful Quality, Safety and Health Information initiatives underway in Australia but these appear fragmented and uncoordinated. There are many questions on how implementation will really take place and whether adequate resources will be available to support the various initiatives.*
- It appears that multiple groups are developing national indicator which could result in, overlap, duplication of effort, and extra burden for data submitter. Such an approach can also lead to multiple conflicting data standards.*
- COAG is very helpful in getting consensus on collection of minimum data sets across the country; agreement to collect done at COAG level, thereby leading complete coverage across the country.*

- The various commissions are doing great work (CEC, ACSQHC) in Australia are doing excellent work but there does not appear to be integration and collaboration in their work. There appears to be many questions on how implementation will really take place and whether adequate resources will be available to support the various initiatives.*
- The National focus on setting standards for quality and safety is positive but is creating tension between State and Commonwealth in terms of the plan for implementation.*
- The work done in Victoria on the development of toolkits for redesigning hospital care (ED and surgical) is excellent. The ROI tool developed is very good and should be applied to all projects. Sustainable outcomes achieved through the redesign projects is commendable.*
- Surprised not to have been able to observe a more mature and robust electronic health record in either the private or public system – there appears to be a lag here compared to quality and patient safety benefits and opportunities here/Canada?*
- Work we saw on quality by Commission on Excellence in NSW was impressive and the engagement with the physicians in each of the areas in the field was noteworthy.*

### ***Lessons for Canada***

- National Quality and Safety Goals can drive focus of clinical quality programs.*
- The idea of integrating national or provincial quality and safety goals into accreditation processes is something that should be given more attention in Canada.*
- The engagement with physicians in the quality work being done by CEC in NSW could be a lesson for Canada in terms of engagement across multiple boundaries.*

### **E. Private Health Insurance**

Another key difference between Canada and Australia is that citizens can purchase private health insurance for the entire spectrum of services. In Canada one cannot purchase private insurance for “insured services” in the Canadian system, except for the limited provisions that now exist in Quebec following the Chaoulli case. In Australia at this time about 45% of the population carries private insurance although scope and coverage of plans can vary widely depending on the level of premium one pays.

The Private Health Insurance (PHI) system in Australia is a community rated system (except for the loadings explained below) which means all Australians will pay the same premium at each age group regardless of their health status and their guaranteed acceptance into plans.

Individuals with private insurance can access services in both the private and public sectors and for a variety of reasons, people with private insurance often rely on the public system. Private insurance does provide faster access to services in private hospitals and provides choice in terms of the physician. However, private insurance does not cover the entire cost so there is usually a significant gap that private insurance holders must pay from out of pocket.

The history of private insurance in Australia has been one of continuous policy debate. While private insurance has been a feature of the Australian system since the beginning of the publicly insured system, the uptake on private insurance by the population has varied considerably. In the 1980's there was sharp decline and at one point percentage holding private insurance fell below 20 percent. So the Commonwealth Government instituted a series of measures to encourage people to purchase private insurance. These include:

- A 30% rebate was introduced in 1999 provided by Government to individuals on the cost of private insurance premiums;
- A lifetime coe provision introduced in 2000 that began to penalize people who did not take out PHI for hospital coverage before age 30. The penalty is that there is a 2% loading per year on the cost of the premium taken out after age 30. So an individual taking out PHI at age 40 would pay 20% more for the premium. The loading is capped at 70% and an individual must pay this for 10 years.
- A 1% income surcharge has been place on people with high incomes if they do not take out PHI (single people with incomes over \$70K, and couples over \$140K). *(This is in addition to the 1.5% income tax levy for health care that all Australians pay to support the public system).*

The combined effect of these measures has raised the uptake in PHI from 30% in the early 1990s to 45% in 2012. However, the current debate is now around new legislation to means test the rebate provision. The proposal is to introduce a sliding scale on the subsidy where reductions start at an income of \$83K/\$166K (singles/couples) and the subsidy is eliminated at an income of \$129K/\$258K. An independent review by Deloitte estimates that 1.3 of the current 5.6 million who currently hold private insurance will withdraw from private hospital coverage over 5 years and another 4.3 will downgrade to lower levels of cover. This will cause a premium rise of over 10% and shift costs to the public system that could amount to \$3.8b.

In addition to the faster access and more choice provided by PHI, at least one of the major insurance companies is beginning to introduce a series of measures to both sustain

and improve the health status of their members which also will result in lower costs. HCP is the third largest PHI Company with 1.3 million members.

HCF has implemented many programs with their members to help improve health outcomes. Very many programs focussed on primary care and chronic disease including using handheld devices to communicate health info on diabetes, after hours in home care from GPs. The “My Health Guardian” program monitors health of high users and has shown results using telephone advice and some interventions. – reduced growth rates in costs from 10.2 % to 3.3%. Program involves 25,000 people.

There is significant integration between the public and private sector in Australia. As noted above, holders of PHI also access public services. Other types of linkages include physicians generally practice in both public and private hospitals and public and private hospitals are often collocated to share services. In addition, the Commonwealth continues to pay 75% of the Schedule of Medical Benefits for medical services provided in private hospitals which means that the PHI normally picks up the other 25% and the patient picks up the remaining difference from the Schedule rate and what the physician charges.

#### ***Insights from the Canadian Group***

- Australia has found a way for both private and public hospitals to co-exist with government offering incentives for the public to carry private insurance.*
- Private hospitals have been successful in reducing wait times for targeted elective surgeries in public hospital system.*
- It is interesting to see how a public and private system can “co-exist” in a federal/state context.*

#### ***Lessons for Canada***

- There is an opportunity to explore aspects of the private hospital model to see how it might co-exist without undermining a public system.*
- Further exploration of health outcomes and the financial impact of having both private and public hospitals co-existing on a long term basis would be beneficial.*

## **4. Overall Study Tour Conclusions**

#### ***Insights from the Canadian Group***

- Although there are many similarities between the two countries, there are also many differences that we can learn from.*

- *The complex payment system (e.g. commonwealth/state, public/private) in Australia makes it difficult to align all the levers and incentives to drive system reforms in the same direction.*
- *Although the systems are different (e.g. public/private distribution of funding for health service, and the Commonwealth versus state powers); the issues and priorities are the same – aging population, chronic disease management, integration of service, fiscal sustainability of the system, primary health care reform, health promotion etc.*
- *Good overview of Australian healthcare system at commonwealth, state and local level. Wide scope of speakers and generosity of time to share their structures, systems, successes and areas to improve/focus on and learn from other system.*
- *Different funding systems – commonwealth versus states as well as public/private does create some tensions. Some leaders we met with were quite open with this. Mix of public and private system creates inequity in terms of access and therefore quality and perhaps outcomes of care.*
- *E health continues to be an area for investment and planning-- in most health sectors Australia is still working with hybrid systems.*
- *It was great to have had such access to senior leaders and decision makers from a Commonwealth and State perspective – this should not be understated.*

### ***Lessons for Canada***

- *A key difference between Australia and Canada is the presence of a National Reform Agenda in Australia. While there are many Commonwealth – State challenges around implementation of that agenda, there is agreement on overall directions. The COAG process appears to have been very instrumental in creating this common direction and commitment.*
- *There are more opportunities to be successful in reforming the system when you have one body as is the case in Australia that is largely responsible for the allocation of funds to all components of the health system, including medical services.*
- *There are many process redesign tools and experience in Australia, particularly in the State of Victoria that would be helpful in Canada.*
- *Australia’s new national system around health professional registration and regulation is something that Canada could learn from.*

- *While much has been accomplished in Canada around innovative approaches to move services to ambulatory settings, there appears to be even greater variability on this in Australia suggesting we still have more to achieve in this area in Canada.*
- *The wait list issues we are constantly struggling with in Canada are not nearly as serious in Australia. Related to this there is virtually no issue in Australia with patients in hospitals waiting for alternate levels of care – the ALC issue we are constantly dealing with in Canada.*
- *Australia is attempting to embed national quality and safety standards within accreditation processes. This is still at a very early stage of development but is an area Canada should watch and consider.*
- *Given that many provinces are moving towards Activity Based funding models, it will be instructive to carefully follow the Australian experience on this as they are implementing this on a national level.*
- *The public – private mix and the very prominent presence of a parallel private system in Australia is a marked area of contrast between the two countries. However, the relative merits of this approach are not consistently clear especially when one considers the same physicians work in both systems and there are high out of pocket costs for people using the private system even when they have private health insurance.*
- *While there are some key new developments in Australia around primary health care, especially with the new Medicare Locals, Canada’s approach to primary health care despite all its limitations appears to have some added strengths including the use of Nurse Practitioners and Inter Professional teams.*
- *On most measures of efficiency, quality and access the Australian system is comparable and in many cases better than Canada. Some insight into this can be gained from the tables in Appendix 2. However, at the overall country level in terms of resources expended on health expressed as the percentage of GNP, the numbers are not comparable as Australia does not include the vast majority of expenditures on aged care in health expenditure.*

## **APPENDICES**

### **Appendix 1: List of Australian Presenters and Participants**

Visit the Canadian College of Health Leaders' [web site](#) to view available presentations.

#### **NATIONAL/COMMONWEALTH LEVEL**

1. Dr. Tony Sherbon, Acting CEO of the Independent Hospital Pricing Authority
2. Martin Fletcher, CEO, Australian Health Practitioner Regulation Agency
3. Mark Cormack, Chief Executive, Health Workforce Australia
4. Louise Sylvan, CEO, Australian National Preventive Health Agency
5. Leanne Wells, CEO, Australian General Practice Network
6. Rod Young, CEO, Australian Aged Care Association
7. Brian Johnston, CEO, Australian Council of Healthcare Standards
8. Dr. Shaun Larkin, CEO HCF (private health insurer)
9. Dr. Michael Smith, Clinical Director, Australian Commission on Safety and Quality in Health Care
10. Dr. Jeffrey Braithwaite, Professor, Australian Institute of Health Innovation, University of New South Wales
11. David Kalisch, Director (CEO), Australian Institute and Welfare
12. Kate Copeland, National President, Australasian College of Health Service Management (ACHSM)
13. Daryl Sadgrove, CEO, ACHSM
14. Sue Thomson, Executive Director, Professional Development, ACHSM

#### **STATE LEVEL**

##### ***State of New South Wales (NSW)***

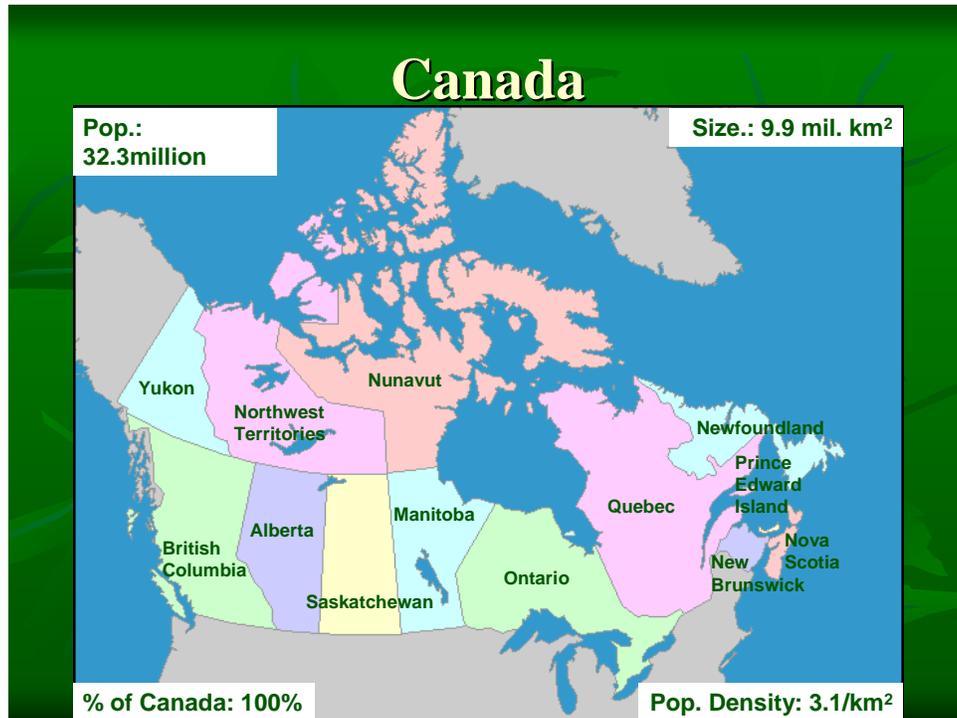
15. Dr. Mary Foley, Director General, Ministry of Health
16. Carmen Partner, Director, Centre for Aboriginal Health
17. Dr. Diane Watson, Chief Executive, Bureau of Information
18. Dr. Peter Kennedy, Deputy CEO, Clinical Excellence Commission
19. Robert Cusack, CEO, St. Vincent's Private & Mater Hospitals
20. Jonathon Anderson, Ex Director, St. Vincent's Public Hospital
21. Dr. Brett Gardiner, Director of Clinical Governance, St. Vincent's Public Hospital
22. Dr. Peter McGeorge, Program Director – inner city Health and Mental Health, St. Vincent's Public Hospital

##### ***State of Victoria***

23. Bruce Prosser, Director Funding & Information Policy Unit, Victoria Department of Health
24. Bernadette McDonald, Director, Health Service Reform & Innovation
25. Dr. Paul Ireland, Manager Victorian Quality Council

26. Tony McNamara, A/Manager, Service Performance & Governance
27. John Rasa, CEO, General Practice Victoria (GPV)
28. Marianne Shearer, CEO, Inner East Melbourne ML
29. Michelle Thompson, CEO Northern ML
30. Chris Carter, CEO, Inner Northwest ML
31. Jason Trethowan, CEO, Barwon ML
32. Claire Harris, A/Professor Centre for Clinical Effectiveness, Southern Health
33. Richard King, A/Professor & Director, Medicine Program Chair, Technology/Clinical Practice Committee, Southern Health
34. Wayne Ramsey, A/Professor & Chief Medical Officer, Executive Director Medical Services and Quality
35. John Turner, CEO, Bentleigh Bayside
36. Trevor Carr, Chief Executive, Victorian Healthcare Association
37. Dr. Michael Walsh, CEO, Cabrini Health

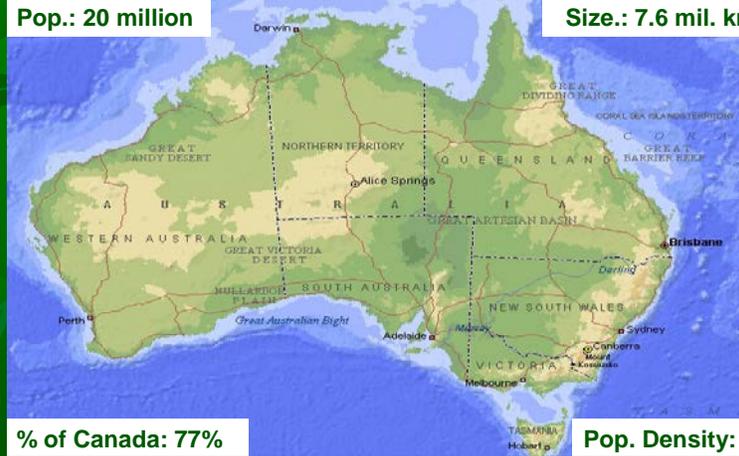
## Appendix 2: Comparative Health Statistics



# Australia

Pop.: 20 million

Size.: 7.6 mil. km<sup>2</sup>



% of Canada: 77%

Pop. Density: 2.4/km<sup>2</sup>

## Country Basic Facts, 2009

| Country     | Pop. (Million) | Size (km <sup>2</sup> ) | Size % of Canada | Pop. Density         |
|-------------|----------------|-------------------------|------------------|----------------------|
| Canada      | 33.4           | 9,997,140               | 100%             | 3.3/km <sup>2</sup>  |
| Australia   | 22.0           | 7,600,300               | 77%              | 2.8/km <sup>2</sup>  |
| UK          | 60.9           | 244,110                 | 2.5%             | 253/km <sup>2</sup>  |
| NZ          | 4.3            | 268,680                 | 2.7%             | 16.0/km <sup>2</sup> |
| Sweden      | 9.3            | 449,964                 | 4.5%             | 21/km <sup>2</sup>   |
| Netherlands | 16.4           | 41,526                  | .41%             | 395/km <sup>2</sup>  |

Source: OECD Health Data 2011, for Pop. (Million)

## Comparative Health Systems, 2009 (or latest year)

| Country                 | AUS   | SWE   | NZL   | UK    | NLD   | CAN   |
|-------------------------|-------|-------|-------|-------|-------|-------|
| Population (millions)   | 22.0  | 9.3   | 4.3   | 60.9  | 16.4  | 33.4  |
| % Pop over 65           | 13.3  | 17.9  | 12.8  | 15.8  | 15.2  | 13.9  |
| % of GDP                | 8.7   | 10.0  | 10.3  | 9.8   | 12.0  | 11.4  |
| Per Capita Health Exp.* | 3,445 | 3,722 | 2,983 | 3,487 | 4,914 | 4,363 |
| % Public                | 68.0  | 81.5  | 80.5  | 84.1  | 79.0  | 70.6  |
| % Private               | 32.0  | 18.5  | 19.5  | 15.9  | 21.0  | 29.4  |

\* SUS PPP

Sources: OECD Health Data 2011 and OECD Health at a Glance 2011

**Health Care Resources**  
**% of Workforce in Health and Social Sector, 2009**  
**(or latest year)**

|                |      |
|----------------|------|
| Canada         | 11.6 |
| Australia      | 11.1 |
| United Kingdom | 12.9 |
| New Zealand    | 10.4 |
| Sweden         | 15.7 |
| Netherlands    | 15.9 |

Source: OECD Health at a Glance 2011

**Health Care Resources, 2009 (or latest year)**

|   | AUS  | SWE  | NZL  | UK   | NLD  | CAN  |
|---|------|------|------|------|------|------|
| Hosp. as % of Tot. Emp.                 | 39.4 | 44.0 | 35.9 | NA   | 31.4 | 28.0 |
| Offices of Physicians as % of Tot. Emp. | 13.9 | NA   | 6.7  | NA   | 8.2  | 14.1 |
| Pharm as % of Tot. Emp.                 | 14.6 | 12.5 | 9.3  | 11.6 | 9.6  | 17   |
| Acute Beds/1000                         | 3.8  | 2.8  | 2.3  | 3.3  | 4.7  | 3.3  |

Source: OECD Health Data 2011

## Health Care Resources Practitioner/1000 Population, 2009 (or latest year)

|            | AUS  | SWE  | NZL  | UK  | NLD <sup>1</sup> | CAN <sup>1</sup> |
|------------|------|------|------|-----|------------------|------------------|
| Physicians | 3.0  | 3.7  | 2.6  | 2.7 | 2.9              | 2.4              |
| Nurses     | 10.2 | 11.0 | 10.5 | 9.7 | 8.4              | 9.4              |

Note:

1. Data include not only doctors providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc.

Source: OECD Health at a Glance 2011

## GP-Specialist ratio, 2009

| Country        | GP, % | Specialists, % | Unspecified**, % |
|----------------|-------|----------------|------------------|
| Canada         | 47.4  | 51.2           | 1.5              |
| Australia*     | 49.8  | 47.9           | 2.4              |
| United Kingdom | 29.8  | 66.1           | 4.4              |
| New Zealand    | 32.0  | 53.2           | 14.8             |
| Sweden*        | 16.7  | 50.2           | 33.1             |
| Netherlands*   | 24.9  | 45.9           | 29.2             |

Data include interns/residents

\*Data for 2008

\*\*Unspecified include interns/residents if not reported in the field in which they are training, and doctors not elsewhere classified

Source: OECD Health at a Glance 2011

## Physician supply - gender, 2009

| Country        | Male, % | Female, % |
|----------------|---------|-----------|
| Canada         | 61.8    | 38.1      |
| Australia*     | 64.9    | 35.1      |
| United Kingdom | 56.8    | 43.0      |
| New Zealand    | 59.9    | 40.1      |
| Sweden*        | 55.4    | 44.6      |
| Netherlands*   | 56.5    | 43.5      |

\*Data for 2008

Source: OECD Health Data 2011

## Wait times to see a doctor, 2011

| Country        | Same-day appointment, % | 6+ days, % |
|----------------|-------------------------|------------|
| Canada         | 51                      | 23         |
| Australia      | 63                      | 10         |
| United Kingdom | 79                      | 2          |
| New Zealand    | 75                      | 5          |
| Sweden         | 50                      | 22         |
| Netherlands    | 70                      | 12         |

Source: 2011 Commonwealth Fund International Health Policy Survey in Eleven Countries

## Wait times to see specialist, 2010

| Country        | Less than 4 weeks, % | 2 months or more, % |
|----------------|----------------------|---------------------|
| Canada         | 41                   | 41                  |
| Australia      | 54                   | 28                  |
| United Kingdom | 72                   | 19                  |
| New Zealand    | 61                   | 22                  |
| Sweden         | 45                   | 31                  |
| Netherlands    | 70                   | 16                  |

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries

## Pharmaceutical expenditure

| Country         | Share of health care budget, 2009 | Per capita annual growth rate, 2000-2009 |                                |
|-----------------|-----------------------------------|--|--------------------------------|
|                 |                                   | nominal                                  | adjusted for general inflation |
| Canada          | 17.0                              | 6.8                                      | 4.5                            |
| Australia*      | 14.6                              | 6.8                                      | 2.6                            |
| United Kingdom* | 11.6                              | 5.0                                      | 2.2                            |
| New Zealand**   | 9.3                               | N/A                                      | N/A                            |
| Sweden          | 12.5                              | 4.1                                      | 2.3                            |
| Netherlands     | 9.6                               | 5.7                                      | 3.4                            |

\*Latest data are for 2008

\*\* for NZ data is not available until 2004

Source: OECD Health Data 2011

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