

A long-term national health strategy

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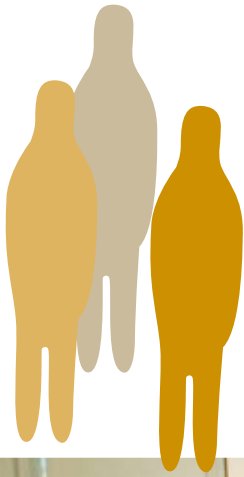
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OVERVIEW

There were two discussions on the Saturday of the summit, one focused on 2020 ambitions and goals and one that brainstormed and generated ideas to support the ambitions and goals. A number of ideas were generated in both sessions. Ideas are listed at the end of each of the 'Ambitions' sections where they were not identified or further developed in the 'Ideas' section. If an idea was discussed in more than one group, efforts were made not to highlight and 'box' it more than once.

On the Saturday afternoon the group came together and voted on their 'top ideas'. These ideas were presented in the interim report. The stream's eight top ideas were as follows:

- Create a Health Equalities Commission.
- Create a National Preventive Health Agency—akin to VicHealth funded by taxes on tobacco and unhealthy food.
- Ensure evidence based allocation of health resources.
- Set up a regional health partnership—akin to the ASEAN model.
- 'Fast fruit, fresh food' - making healthy food choices easy in schools and regional areas.
- Completely rethink the shape of the health workforce.
- Promote better translation of Australia's research efforts into commercial and health outcomes.
- Create a 'Healthbook' web-based personal record—like Facebook.

On the Sunday participants were given the opportunity to discuss the stream's input into the interim report. They also voted on 'out-of-the-box' ideas and the information that would be presented to the full summit on the Sunday afternoon. The stream's top out-of-the-box ideas were as follows:

- a 'Wellness Footprint'
- first aid training for all children, the training being delivered by volunteers
- an opt-out system for organ donation
- health impact statements
- half an hour of physical activity built into sedentary jobs.

AMBITIONS

The Health stream initially discussed what ambitions were necessary in order for Australia to consider a long term health strategy. Ambitions were grouped into five main themes—healthy lifestyles, health promotion and disease prevention; the health workforce and service provision; addressing health inequalities; future challenges and opportunities in health; and health research, research translation and research training.



Healthy Lifestyles, Health Promotion and Disease Prevention

Under the theme of healthy lifestyles, health promotion and disease prevention, the group put forward the following ambition: 'By 2020 we will have achieved a healthier lifestyle, through universal access to a clever wellness-focused evidence-based system with due regard to the environment in which we live'.

Health Workforce and Service Provision

Five main ambitions were identified under this theme.

Ambition 1: By 2020 Australia should aim to become the most healthy, health literate, physically active and health conscious nation.

Ambition 2: By 2020 there need to be greater links between health and all sectors.

Ambition 3: By 2020 we need fair distribution of health.

Ambition 4: By 2020 we need a single integrated community-centric health care system with one set of legislation and common data across the nation to inform resource allocation based on needs.

Ambition 5: By 2020 we should be self-sufficient in producing our workforce and assisting in enhancing health throughout the region.

Addressing Health Inequalities

The following ambitions were identified under this theme:

- equivalent health outcomes for all Australians, with a particular focus on closing the gap in life expectancy between Aboriginal and Torres Strait Islander people and the wider Australian population
- adequate health providers
- rationalising governance, management and funding of the health system, including research
- a person- and family-centred health system, collaborating across disciplines
- a system focused on prevention
- a system that prioritise health and wellbeing in the early years (from conception to adolescence)
- an open sharing of health information
- becoming world leaders in the development and use of technology and research
- having a rapidly responsive health system to deal with emerging global health issues.

Future Challenges and Opportunities in Health

The following ambitions were identified under this theme:

- a human-centric single health system focused on wellness
- measurement of outcomes and health practices based on evidence and outcomes
- productive ageing

- a diverse health workforce with new boundaries
- research.

Health Research, Research Translation and Research Training

Under the theme of healthy lifestyles, health promotion and disease prevention, the group put forward the following ambition: ‘Good health outcomes and systems are underpinned by quality research. The research agenda must better reflect 2020 priorities. A fixed percentage of GDP should be spent on research and development (aspiring to the OECD benchmark).’

Once these ambitions were identified, participants broke off into five groups to further discuss themes and ideas under each ambition.

GROUP 1: HEALTHY LIFESTYLES, HEALTH PROMOTION AND DISEASE PREVENTION

Evidence-based preventive health policy and programs

The following views were put forward:

- There is a strong need for evidence-based health policy.
- This could be assisted by providing legitimate Commonwealth data to the public; the data held by Commonwealth agencies such as the Department of Health and Ageing and Medicare Australia, including linked administrative data, represents an untapped resource that should be used to support transparent evidence-based preventive health policies. It will help us understand what works well and what works badly and should be made publicly available and used to support measurable targets.
- Key targets should be set in health policy to achieve real outcomes. A program of visiting infants and new mothers in South Australia was given as an example of an intervention in health promotion that begins early in the life of a person and targets both the mother and the infant.
- Health funding should be redirected to prevention to stop people from coming into the health system later in life with chronic diseases; it was suggested that 1 per cent of the hospital budget and resources could be directed into health prevention. There was some disagreement on moving resources from hospital budgets, which some participants claimed are already underfunded.
- Some consideration should be given to complementary medicines. This is a high-spend area in the community, and the traditional health system should embrace the sector if there is research and evidence that such medicines do contribute to the health system.

A focus on ‘wellness’ in policy development, as opposed to responding to ‘illness’

Participants were of the view that the health system is currently focused on illness and that there is a real need to focus on wellness. It was felt that the word ‘prevention’ is ‘siloed’ as a term. There is a need to refocus the concept of health prevention to mean an investment in wellness and wellbeing. The following ideas were brainstormed:

- Encourage all families and people to engage in ‘wellness’ activities.
- Develop a ‘wellness footprint’ that would target specific outcomes—for example, childhood obesity.
- Give individuals the knowledge, opportunity and ability to embrace positive health behaviours.



- Enable older people to achieve healthy participation in the community and value them more.
- Health care is not a commodity but an investment: there is a need to change the way health is viewed in the community if we are to achieve a real change in health behaviour patterns.
- Help people manage their conditions better and have a better engagement with the health care system.
- There is too much focus on illness in the study of medicine. we need more education on prevention and wellbeing at schools and medical schools.
- Every child and adult, organisation and employer should have a full understanding and the opportunities to engage in behaviours that enhance their wellness. A wellness footprint would be a way of measuring how you or your organisation is promoting and encouraging wellness.

A focus on health policy that is integrated with broader government policies

The following views were put forward:

- Preventive action does not have a significant profile outside health, but it greatly affects all areas of life and wellbeing. The view was expressed that there is a need to set targets for people, cities and hospitals and that the government needs to consider the health and social impact of all government policy in all policy settings.
- There is a need to focus on the political economy: infrastructure should be established that will make positive choices the easy choices. What is it about society and culture that makes things such as intoxication acceptable? Why do our children pursue this?
- Government needs to be accountable for our aspirations, targets and policies and for policy implementation and resourcing. It needs to be accountable for the outcomes of this summit. There is a Community stream at the summit, and it is important to link this discussion back into what is happening in that stream. There is a need to put some incentives into the system to support interdisciplinary action.
- A 'life-course' approach is desirable—activities for children, young people and adults. This needs a whole-of-government approach.

Smart cities and towns

The following views were expressed:

- Smart cities and towns aspire to be healthy cities promoted on the basis that there is a link between the nature of our cities, environment and health.
- As a nation, Australia needs to plan for healthy cities using key planning tools—town planning, good architecture, and social modelling.
- We need to rethink how we plan and develop our cities. Tharangau, near Townsville is a good example of urban planning that encourages healthy living and social and environmental integration.
- Smart cities will support the measurement for wellness or a health rating that measures equity of access to things such as transport and healthy food, to help build healthy societies.
- We need to better value the community and how it contributes to health.

Recognising individual and population ageing as major opportunities

The group noted the importance of recognising individual and population ageing as a real opportunity to reassess how we structure the health system. It was felt that there is a need to focus on health prevention and promotion to extend the useful life of the ageing population through enabling older Australians to be healthy, productive and able to contribute to Australia. The following suggestions were made:

- Fundamentally rearrange work, care, acute treatment and prevention to improve access by the ageing population.
- We need a funding system that supports this as an opportunity: this can be cost-neutral but effective funding.
- Develop a two-pronged supplementary health insurance system—one for long-term care and one for catastrophic conditions and illness, as a result of injury, for example.
- This could be done through another type of Medicare levy, for aged care and for severe conditions and illnesses.
- Giving people greater mastery over their own health is a key concept for any age.

The health of Aboriginal and Torres Strait Islander people

The group considered that Australia must close the gap for Indigenous people and their health indicators using evidence-based approaches and target setting. It was agreed that it is vitally important to focus on the needs of Aboriginal and Torres Strait Islander people through giving them the knowledge to make decisions, the wherewithal to make those decisions, and access to the services.

The Commonwealth to run the hospital system

The following ideas views discussed:

- a universal health card with universal information
- one health system using science to deliver better health. This would include use of a 'Facebook' approach to maintaining and accessing individual health records at the national level
- the need for *one* health system. Cost shifting has become an art form in this country
- the government to be accountable for the policies it develops. We need to ensure that there are funds behind policies for implementation.

Preventive action: thoughts from the Youth Summit

The following thoughts from the Youth Summit were put forward:

- a health system equitable for all ages and all socio-economic groups—a system that does not discriminate
- shifting from a system focused on illness to encouraging and valuing wellness
- a youth-focused and -driven mental health program that is relevant to young people, using schools, the media and movies



- developing the concept of ‘mental health first aid’—raising awareness and destigmatising mental illness through engendering in the population an understanding of how to deal at a basic level with mental health problems.

Mental health

The group agreed that by 2020 Australia should have better mental health: at present poor mental health is a significant burden. Australia can become a leader in this area, to link better wellbeing, brain function and healthy lifestyle to improved outcomes for mental health issues. The following views were expressed:

- Evidence shows that better living leads to a healthier brain—an aspiration for a clever health system that uses science and is not ideologically driven.
- Any approach to mental health must be multi-disciplinary. There are services that are doing this on the ground, but the information does not get out there.
- Consider establishing an Institute for Better Mental Health.

A clever health system

There is a need for a smarter, single health system that is integrated more broadly with government policy to leverage and influence health outcomes. The following issues and ideas were raised:

- People will always be sick, so there is a need to be careful not to cut hospital funding to support health prevention policy.
- There is a need for a culture of perceived control over one’s life, rather than being tossed around in the system. This applies to all areas of health.
- We need to empower people to use and understand the health system.
- A clever health system needs to be integrated at all levels, allowing for active participation of all health professionals to focus not only on illness but on wellness; allied health professions need to be included in the mix.
- Health is part of other streams: there is a need for intersectoral collaboration in a range of areas.
- There is a need for interdisciplinary education and integration and being able to work together.
- Oral health should be part of the central theme in health prevention.
- The hospital system needs to be smarter, and financial incentives need to be incorporated.
- There is a need for a patient-responsive workforce—patient- and family-centred care, care that is community focused, person-focused care.
- We need affordable health care that caters for every Australian; take a holistic personal view and a whole-of-system view to deliver effective health care.
- Australia is not good at planning in a regional sense for our health care; we can learn much from other countries in the region; for example, Japan has an ageing population that is well cared for and productive.
- We should use emerging medical technologies to cut the cost of the provision of health care. Medical technologies can be the driver of effective health care.

- We should work on avoidance of the chronic consequences of disease. There is a need to appropriately treat the consequences of chronic health care—for example, transplant or dialysis. Good care of people with chronic and acute disease will save the country thousands of health care dollars by increasing the productivity of this group.
- We need to retrain health professionals so that there is a movement from illness to wellness—to help bring about a cleverer health system.
- We need to do much in our clever health system in integrating health professionals and health services and helping them participate in the wellness area.
- We also need to make a lot of gains in interdisciplinary education—there is too much training in silos with a focus on illness, not wellness.

Alcohol abuse

The group put forward the following ambition: ‘In the year 2020 we want to live in a society that does not accept “intoxication” as acceptable’. It was felt that this calls for an integrated approach, including marketing and government action. The view was expressed that to do this Australians need to change what they see as ‘normal’, just as the perception has changed about smoking. To achieve this, it was suggested that perhaps ‘flavoured’ alcohol could be banned as it currently attracts young people to consume large amounts of alcohol. It was felt that the community is not bothered by the problem of overindulgence but is bothered by the issue of drinking and ‘safety’: this is the community’s main concern. It was reiterated that there is a need to change social perception of what is acceptable, just as has occurred with drink–driving. It was said the government can assist by implementing strong policies.

It was suggested that there is a need to involve the education system to achieve this, starting with healthy lifestyle choices such as beginning the day with breakfast and doing some physical activity. It was suggested that education needs to start at younger ages, including at schools: the education system is an important partner in health; it is an intersectoral responsibility. The view was also put forward that schools cannot be the be-all and end-all as there are competing priorities there in terms of numeracy and literacy. To this end, it was felt that there is also a community and parental responsibility.

In dealing with this issue the group considered there was a need to:

- redefine the unacceptable—similar to the issues of smoking and road deaths
- bring the impact of the problem of alcohol to the public’s attention
- move away from a focus on individuals to the structures behind this: what makes the unhealthy choices the easy choices? How do we change these structures to make the healthy choices the easy choices?

A view was put forward that this type of approach to policy and program implementation would risk the notion of a ‘nanny state’ and over-restriction of behaviour—in particular, where the view exists that health behaviour is a personal responsibility. It was felt that there needs to be an understanding that this response will occur and that health promotion must not succumb to these pressures. It was also considered that the program would require good intervention outcome measures, something more meaningful in the evaluation of programs, with a link to evidence and a resolution of the contradiction in existing policies—for example, alcohol availability and the abuse of alcohol.



Unpredictable health challenges and Australia's role in the region

The group considered that unpredictable challenges such as emerging infectious diseases will occur and that Australia needs to consider how it will prepare for the unknown. The following views were expressed:

- Australia is not well placed to respond regionally and has a poor capacity to respond nationally. To this end, there is a need for coordination of prevention, preparedness, response and recovery integration of national efforts in emerging infectious diseases and the possible catastrophic events.
- There is a lack of national skills for catastrophic events. Although these types of events are high risk with a low probability, they have a high risk.
- This is a cross-sectoral question relating to animal health, robust surveillance systems, emergency management agencies, and a whole-of-government response.
- Australia needs to be well placed internally and through its regional partnerships to minimise the impacts of possible emergence of communicable diseases such as H5N1 but also of things such as changes in climate change and the possible shift down of communicable diseases currently common in other countries. These issues are cross-linked closely to national security, agriculture and globalisation.
- Australia can contribute in relation to health in our region but can also learn much from other—for example, learn about affordable and healthy ageing from countries such as Japan.

Government accountability

A view was put forward that there are issues around elections and the election cycle that reinforce the view that no government accepts policy failure: they just transform bits of the failed policies to try and respond to policy failure. The following views were also expressed:

- There is a need for good performance measures for programs that are put in place.
- There is a need to understand what is working well and what isn't. An audit could be undertaken.
- Most of what is called evaluation is really just a description of activities rather than a focus on the intended outcomes of the programs. The concept of evaluation also supports and is linked to the evidence-based approach to policy and programs discussed earlier.
- A new government can examine what worked and what did not without 'shooting itself in the foot'.
- Why just government: should industry also be accountable? There is a need for health to work more closely with the private sector because this will create an opportunity for interventions not yet seen. There is potential for industry intervention and collaboration that is not yet tapped.
- There is a real opportunity for the new government to achieve real outcomes, involving decentralisation, change of measures and change of outcomes.
- How can governments be encouraged to dump bad policies—for example, the 30 per cent rebate on private health insurance?

The following ideas were identified from the 'Ambitions' session but were not further developed in the 'Ideas' session.

IDEAS

- 5.1 Develop a two-pronged supplementary health insurance system—one for long-term care and one for catastrophic conditions and illnesses (for example, as a result of injury).
- 5.2 Introduce a Medicare levy for aged care and for severe conditions and illnesses.
- 5.3 Introduce a universal health card with universal information.
- 5.4 Mental health:
 - 5.4.1 Develop a youth-focused and -driven mental health program that is relevant to young people, using schools, media and movies.
 - 5.4.2 Introduce mental health first aid, a common basic understanding in the population of how to deal at a basic level with mental health issues.
 - 5.4.3 Establish an Institute for Better Mental Health.
- 5.5 A clever health system:
 - 5.5.1 Have a system integrated at all levels, allowing for active participation of all health professions to focus not only on illness, but also on wellness.
 - 5.5.2 Financial incentives should be incorporated in the hospital system.
 - 5.5.3 Use medical technology to cut the cost of the provision of health care.
- 5.6 A program to combat alcohol abuse:
 - 5.6.1 Redefine the unacceptable: change community views on alcohol use, similar to the change that has occurred with tobacco use.
 - 5.6.2 Bring the impact of alcohol abuse to the public's attention.
- 5.7 Develop regional partnerships to minimise the impacts of communicable diseases such as H5N1.
- 5.8 Conduct a health audit to identify the programs that are working well and those that are not.

Preventive action

The group suggested that national taxation on cigarettes combined with a volumetric tax on alcohol be used to fund a national preventive health agency that would focus on positive lifestyle initiatives. It was felt that this would require a national health effort that is fully integrated with broader health strategies, is intersectoral, and has a supportive government framework that will ensure a policy focus on wellness and national health. It was suggested that a 2.5 cent increased tax on each cigarette plus a volumetric tax on alcohol (based on alcohol content) would lead to funds of about \$500 million a year to support the agency. Additionally, a 'junk food' tax could be introduced—that is, a tax on high-energy, low-nutrient foods. It was agreed that the revenue from these taxes must flow back to fund the work of the agency.

It was felt that an holistic approach to wellness needs to be adopted and that this policy would encourage good behaviour and require the community to 'pay' for poor dietary habits, with funds raised to be fed back to preventive strategies in that domain. The agency could develop evidence-based policies and undertake program design and implementation. Policies would need to be broadly integrated with parallel policy areas such as education and broader social policy.



The following views and concerns were also raised:

- The agency must focus on preventive health across sectors and be intergovernmental—Commonwealth, state and territory and local governments.
- Consideration should be given to abolishing cigarettes and alcohol brought into the country duty free.
- Is a bricks and mortar agency or institute necessary? It could be a committee or a task force—or like a national version of VicHealth. Thailand also provides a similar example.
- An agency needs dedicated infrastructure and capacity, but it does not need to be a building. The notion of an agency would be preferred, not just a committee or a task force, and it needs to be independent of government, with a focus on leadership in these areas.
- It is important that there is something like a link into the Prime Minister’s department so that it does not get lost or sidelined. It needs to be actively championed at the very top, through a mechanism that is central and engages the relevant government portfolios, such as health, education and employment, treasury and rural issues portfolios.
- If it was based on specifically targeted revenue raised through taxes it could be used to deliver programs.
- Taxing things such as food might also make food manufacturers change their food products to make healthier choices.
- The agency must focus across the life course and the most disadvantaged groups.
- Oral health should be included—for example, one government-subsidised visit a year to the dentist.

IDEA

5.9 A National Preventive Health Agency:

- 5.9.1 tax hypothecation of cigarettes, alcohol and junk-food products to fund the agency
- 5.9.2 a 2.5 cent increase in tax on each cigarette
- 5.9.3 a volumetric tax on alcohol
- 5.9.4 a tax on high-energy, low-nutrient foods (a junk-food tax)
- 5.9.5 abolition of bringing duty-free alcohol and cigarettes into Australia
- 5.9.6 oral health to be on the preventive health agenda.

Plans for smart cities: urban environment and planning

The group discussed health and lifestyle plans for every city, with a focus on all areas, including suburbs—we need to connect places where people like to go, such as sports stadiums and water areas and parks—and a particular focus on socially disadvantaged groups.

A ‘wellness footprint’. There is a direct connection between the health of people in our cities and the nature of the urban environment. The group suggested the development of a wellness footprint to gauge the health prevention and wellness criteria in various areas, such as schools and the workplace.

In support of these ideas, the following suggestions were raised:

- connecting places within cities—for example, building cycle paths
- connecting places where people want to go (for example, lagoons for swimming) to places you'd like them to go to (for example, art galleries). The Thurangerry River plan is an example
- moving away from car-centric cities—base planning of future cities on cycle and walking paths, but based on linking areas of importance
- as part of urban sprawl, bringing jobs to outer suburbs and town centres. Do not concentrate the majority of jobs in the city centres. Decentralise
- health needs being on the agenda of urban planners
- a focus on disadvantaged groups.

IDEA

5.10 Develop health and lifestyle plans for every city.

Positive social marketing

The group agreed on the idea of positive social marketing strategies. It was considered that these types of strategies would need to take into account accessibility to products and to all population strata, especially the lower socio-economic groups. It was thought that social marketing of strategies would require strong political endorsement, such as from the Prime Minister. Additionally, this policy may be integrated more broadly with the corporate sector and industry, with a view to being engaged. Furthermore, these types of policies may be integrated with the smart cities concept and integrated more broadly with other social policy agendas.

The following views were also raised:

- It is not just about stopping some types of advertisements and marketing but also about positive marketing of healthy behaviour—social marketing.
- Use aspirational messages from high-profile people and personalities—for example, sports people.
- There is also a role for pushing negative messages—for example, making smoking unacceptable.
- It is not just about taxes: the change with tobacco was not just about increased tax but also about banning tobacco advertising.
- There may be a case for restricting the advertising of junk food to children. It is not just about advertising but marketing more generally and would cover alcohol and energy-dense nutrient-poor foods.

IDEA

5.11 Use positive social marketing to encourage healthy living by making poor health habits expensive and healthy living habits less expensive. Consider restricting advertising of junk food to children.



Education and schools

The following views were put forward about the place of education and schools in developing healthy lifestyles:

- If you can govern the behaviours of children aged between 5 and 8 years, you can govern them for a long time.
- Children don't participate in sports because they are nervous about their skills, including coordination. There is a place for school-based sports skills-building activities—for example, running, jumping and ball skills—to prepare them for many sports later on.
- Extend the Active after School program to a program that happens within school hours. This would not necessarily occur through government but could also be supported by corporations.
- Whenever there is a problem, people point to education to solve all problems. But there is only a short time that kids are in schools. On the other hand, it has to be recognised that participation in physical activity does make kids more responsive at school.
- Active transport has decreased over past few decades. Incidental activity has also decreased. At the same time, participation in sports has not changed.
- Schools are not the cause of the obesity epidemic, so do not expect them to cure it.
- Encourage healthy food availability: introduce 'fast fruit' into school and preschool.
- A secondary school mental health literacy program is needed.

IDEA

5.12 Healthy lifestyles and education:

- 5.12.1 Introduce school-based sports skills-building activities—for example, running, jumping and ball skills—to prepare children for many sports later on.
- 5.12.2 Extend the Active after School program to a program that happens within school hours.
- 5.12.3 Introduce fast fruit into school and preschool.
- 5.12.4 Develop a secondary school mental health literacy program.

Workplaces

The view was expressed that the workplace is a place to explore psycho-social issues, including job control, empowerment and participation. There is an urgent need to build up the corporate health focus: occupational health and safety is not working well in Australia.

- Work is an opportunity to progress a modern health agenda and bring employers into the discussion.
- Bring occupational health and safety and health into the same agenda.
- Use the triple-bottom-line accounting system as a mechanism for change.
- The proposed National Preventive Health Agency has a role in establishing research and evidence to help employers establish healthier workplaces. This can encompass everything from workplace health checks to the built environment and how it affects health.

IDEAS

- 5.13 Bring occupational health and safety and health into the same agenda.
- 5.14 Commission the National Preventive Health Agency to develop research and evidence to help employers establish healthier work places.

A physical activity pathway for all Australians at all stages of life

It was suggested that there is an urgent need to address 'inactivity' as a major idea and that a pathway could be managed through primary care. The pathway would need to be a long-term funded and planned model so that people are not lost when they leave school. The 'fitness industry' could be integrated into a support program.

This concept also supports the idea of changing the language to 'investing in health': people invest in shares, why not in their own health? Australians nationally need to change their attitudes to what is OK and what is not OK, what is normal and what is not normal.

IDEA

- 5.15 Develop a physical activity pathway for all Australians at all stages of life.

Strengthening preventive health in the primary health care setting

The group considered that there needs to be general awareness and a change of focus in the population to use primary health care providers as a preventive health care and screening strategy.

This requires education of the nation and how the Australian population uses its primary care facilities. It also raises the issue of workforce capacity and the ability of the primary care providers to adequately provide this service.

The following considerations were raised:

- In the United Kingdom preventive health care targets exist with incentives attached for reaching those targets—for example, the number of blood pressure checks.
- E-health also presents opportunities.
- We should also include getting the appropriate advice from primary care providers about screening programs.
- We need to educate both people and health care providers in seeking and promoting certain preventive activities.
- We need to know what to expect in terms of healthy ageing and how to deal with ill-health that might be linked to ageing.
- The workforce is forced to be reactive rather than proactive because there is simply not enough time to provide as much care as one would prefer. This will only get worse if workforce issues are not addressed.
- Any of the activities initiated by the proposed National Preventive Health Agency have to be integrated into the effort of primary care.



- Secondary prevention can also be facilitated through primary care.

The view was expressed that there should not be an expectation that primary care can fix this problem: it is much bigger than this, and root causes need to be addressed. It was felt that too many preventive health issues have been saddled onto personal responsibility and back into primary care responsibility. There needs to be a shift of the focus and the language in health to focus on a positive wellness model. It was suggested that a single issue to address is alcohol abuse.

IDEAS

- 5.16 Expand opportunities for providing 'health checks': at present the Medical Benefits Schedule provides only for a 45-year-old health check.
- 5.17 Use primary health care for health screening; that is, people could attend their general practitioner for a health check. At the moment GPs can provide checks for people who come into their surgeries for other reasons.

Regulation of food content and use of a 'traffic light' system in food labelling

The group agreed that the traffic light system and regulation of food content could be immediate and cost neutral. This could change production of food items. The carbon impact of foods and the carbon footprint of each food item produced could also be examined. This would provide another reason to alter food consumption patterns; this is, the food that turns out to be cheapest in terms of the carbon footprint is the food that is healthiest to eat. This concept gives people an additional reason for making healthy food choices.

It was suggested that food manufacturing could be better regulated. Price elasticity is such that even heavily taxed food items would still be purchased by some people. Instead, certain products, such as palm oil, could be banned and manufacturers could be encouraged to make products with 'good' rather than 'bad' carbohydrates.

IDEA

- 5.18 Food content should be regulated and a 'traffic light' system should be used in food labelling.

A whole-of-life wellness model

The group felt there is a need for a whole-of-life wellness model (to include activities and food consumption) supported by the government. It should be a structured program to provide the opportunity for inclusion at all stages of life. It was felt that this is an area of health that has galvanised a significant amount of interest in the community as a whole. The use of existing building blocks within our communities at various stages of life would allow for physical activity and social engagement, and the promotion of wellness could be used.

The following considerations were raised:

- Is there a broader social issue that needs to be addressed about why people stop socialising via sports and more by doing dinner?
- Does there need to be some more thought given to sports that would be more suitable for older people?

- We need a structured program for an unstructured activity. For example, we have had to build a structured program to get kids back to walking to school which used to be an unstructured activity.
- We need to think about promoting activities that people can do that are social but also promote healthy lifestyles.
- The focus cannot just be on what government can do about this: it also needs to be on what the broader community might be able to do.
- Corporations can also be involved here.

IDEA

5.19 Establish a whole-of-life wellness model incorporating whole-of-life activity pathway.

A ‘wellness footprint’

Along similar lines to a carbon footprint the concept of a wellness footprint was discussed, which identified the contribution various things make to the wellness of the community—for example, urban planning, workplaces, schools, and so on. It would be necessary to provide a tool to come up with a score to use internally, or possibly made public so that there is greater public accountability.

It was noted that retirement is very damaging to health. In retirement – older people need a reason to stay engaged. Consideration should be given to abolishing retirement and reinventing different types of productivity.

Out-of-the-box ideas

The group also agreed on the following out-of-the-box ideas.

IDEAS

- 5.20 Introduce the concept of a health and wellness footprint (most votes for this suggestion).
- 5.21 Expand existing national literacy and numeracy assessments to include physical fitness and health literacy, supported by ‘catch-up’ programs for ‘high-risk’ children, delivered away from healthy peers.
- 5.22 Price foods according to their carbon costs. This would involve production (energy and water use), packaging, transport, storage and disposal of waste. It automatically shifts the average diet to healthier foods.
- 5.23 Create a child and young person’s commission (or similar body) to allow education, social and health issues to be coordinated.
- 5.24 Australia should bid to host the International Conference on Patient and Family Centred Care in 2011.



GROUP 2: HEALTH WORKFORCE AND SERVICE PROVISION

Discussion of ambitions

Group 2 discussed five ambitions for 2020.

Ambition 1: By 2020 Australia should aim to become the most healthy, health literate, physically active and health conscious nation

This includes:

- focusing on wellbeing, which will change the focus of how services and policies are developed and implemented
- closing the gap between Indigenous and non-Indigenous Australians as an imperative
- addressing the gap between rural and urban health
- ownership of health outcomes: there must be a sense of mutual ownership to enable people to make choices and direct their own health outcomes, but without losing compassion
- education of children as the key to changing the future. Start at ages 5 to 8, which are the most important years for influencing future diet and exercise behaviours
- increasing the levels of physical activity and having in place a structured framework to support this
- rewards for efforts to reduce health risks at the individual level
- health and safety in the workplace, which also promotes wellbeing. For example, the Victorian Work Health model is funded from the surplus in Workcover and focuses on improving health and wellbeing in the workplace. This shows huge productivity benefits.

Ambition 2: By 2020 there need to be greater links between health and all sectors

The group considered that health has links across all areas of endeavour in Australia. In considering health and linkages, the group canvassed the following matters:

- integrated infrastructure for health and education
- a healthy environment needing infrastructure that supports healthy lifestyle choices, and town planning needing to be more aware of the impact it will have by including activity-consciousness in future community planning
- health being considered in all decision making across the economy and in government, a 'health impact statement' being required for all new policies.

Ambition 3: By 2020 we need fair distribution of health.

The group was concerned that recent evidence shows that the best health outcomes depend on where people live and that this is something that needs to change. In discussing this goal, the following suggestions were made:

- There is a need for a National Institute of Aboriginal Torres Strait Islander Health and Wellbeing to coordinate the health effort in Indigenous communities.

- A healthy nation needs healthy children. We need to focus on both health *and* wellbeing. Healthy children are the seeds for healthy adults.
- All children must get off to the best possible start. Antenatal care for all mothers in the first trimester is essential for healthy babies, with good child health surveillance to support good policy decisions.
- Health is a right, not a commodity, but this requires commitment from individuals, communities and government. Education is a key to informing children about what they can do to maintain their own health to become healthy adults.
- Whole-of-life health approaches should be an underlying concept of all preventive health measures.

Ambition 4: By 2020 we need a single integrated community-centric health care system with one set of legislation and common data across the nation to inform resource allocation based on needs

The group considered that the health system should be owned by the community, not just the medical profession. It was said that patient-centred care is not good enough and that Australia needs to aim for community-centred health that:

- is responsive to the needs of the community and the consumer
- is citizen-centric, with community ownership of local needs and models of local provision
- enables individuals to access their personal health records
- empowers communities to enable provision of services based on local needs
- makes use of data to develop new business models to enable professionals to respond to these changed needs
- is founded on a needs-based model at the community and regional levels
- considers the capacity to pay and creates a sense of worth and value
- challenges health industries to meet community and individual health needs
- uses integrated systems of service models—for example, private and public sector collaboration
- achieves the highest standards in health delivery
- provides information on outcomes for the patient—not just at discharge.

It was noted that the health system must also make better use of information to inform decision making. It was considered that there is a need for:

- better measurement of health outcomes to determine what works and use of performance measurements to evolve the health workforce and guide future investment
- the best possible information—transparency and openness about health information and health systems
- good information management systems to link state and Commonwealth systems and allow timely passage of information
- good information that enables improvements in safety within the system.



Ambition 5: By 2020 we should be self-sufficient in producing our workforce and assisting in enhancing health throughout the region

The following ideas were canvassed:

- Australia should be providing health professionals to the region by 2020 and no longer be a net importer of its health workforce.
- Australia needs a workforce system where citizens and patients have access to the health infrastructure needed for optimal outcomes.
- The funding system should be structured to provide incentives and to ensure an integrated health workforce and its flexible use.
- Australia must be responsible for producing the workforce it needs and helping its overseas-trained workforce to acculturate into the new health and wellbeing model.
- Australia's role should include leading the development of improved health services in our region and supporting and educating those countries' professionals to assist their development. This also strengthens our relationships in the region and aids in strategic positioning.
- It needs to be recognised that health resources are always going to be finite and delivery cannot always be to everyone.

The group considered that the form of the health workforce should undergo radical change. The new system should have:

- less hierarchy and a workforce that is collaborative, integrated, flexible and cooperative
- the best use of innovation in health technologies to revolutionise health care and delivery
- a future focus: convergence of genetics, robotics and nano-technology will revolutionise the way Australia treats and manages health care
- better alignment so the best provider provides the support needed by the individual at the lowest cost and with less demarcation and better use of allied health professionals
- better retention: employers need to be employers of choice, which calls for a more respectful approach to employment.

Finding the new workforce will require strategies to encourage young people to consider health as a career option. The group considered the following ideas:

- Education in schools should include information on both how to help yourself and the different types of health work that are available.
- Secondary education should focus on the science, maths and other subjects that underpin the skills and knowledge for tertiary-level medical training.
- A 'gap year' experience in the health and community services workforce should be encouraged.
- Older workers and people returning to the workforce after a long absence should also be encouraged to consider becoming 'hands-on' health care workers.

The group considered that education of the new workforce should be through:

- tertiary education of the health workforce in a format that inculcates a team-based approach throughout education

- a single nationally accredited modular medical degree that focuses on producing generalists who can expand their knowledge to meet work needs
- a competitive training system to encourage greater flexibility in the options and delivery of medical training
- developing and attracting people to health work and contributing to the region, to achieve and maintain a high standard of education and delivery of services.

The following idea was identified but was not further developed.

IDEA

5.25 Establish a National Institute of Aboriginal and Torres Strait Islander Health and Wellbeing.

The group developed numerous ideas to support its goals and ambitions.

Improving the quality of decision making and policy development

In considering this goal the group thought Australia needs to use data and evidence better as the basis to promote better health outcomes and to design better health policy. The following challenges would be evident:

- A large amount of system and outcome data is held by governments and the specialist colleges but is not being released and used.
- Information is needed from all parts of the continuum, including the citizen's perspective on their treatment and concerns. For example, there is a need to look at which treatment provider is most effective for different treatments; for instance, some forms of incontinence respond well to physiotherapy and do not require surgery.
- There are capacity constraints in the workforce, but data is needed to work these out rather than continuing reliance on anecdotal evidence.
- Timeliness of data is a significant problem.

IDEA

5.26 Use of the health system information to improve the quality of decision making and policy development:

- 5.26.1 combining the data held by governments and specialist colleges with state hospital data to look at the effectiveness of treatment outcomes
- 5.26.2 reducing the system input and output data to focus on consumer and community outcomes, to provide better targeted treatments
- 5.26.3 national online access to a system of health information for tertiary, secondary and primary health care providers and individuals.



A flexible, multi-disciplinary team-based approach to health care

In considering this goal the group agreed that health care needs to become more about person-to-person connections to enable the gathering of information to make the best care decisions.

The view was put forward that a multi-disciplinary team approach would be the best way of meeting the population needs for 2020 and that this would need different approaches to training and education. To support this there needs to be an examination of how to use specialists better and what the right number of specialists is. The workforce must be planned, and changes to support this approach can be delivered through improved education and training, funding and legislative frameworks.

In considering this approach, participants raised the following challenges and suggestions:

- Australia needs to decide what social and health needs must be facilitated by its health system.
- The current response to workforce shortage is to produce more of the same. The response needs to be different and needs to look at occupational distribution.
- The specialist colleges are a barrier to changing the way we do things. They have a vested interest in limiting change and controlling how training is done.
- One option is to use health care workers best suited to tasks at hand and save the specialists for what they need to do.
- Enable the system linkages between the public, private and community care sectors of the health system to interact seamlessly and deliver cooperatively.
- The health and wellbeing role, especially for ageing in place, will need new skills and different types of workers. But we also need to ensure we do not lose human interaction from the equation. Human touch and caring remain an essential element of health care.
- A new form of education and training of health professionals will be needed, but at present the competencies have not been defined. Boundaries between the health professions are a significant issue that will need to be overcome to develop the new type of health worker. Professions and colleges do not help by hiding data.
- Retention within the current workforce and recruitment of appropriately skilled professionals will require significant input and planning.
- The current health system is not sustainable. The expectations of the community need to change to a point where they share responsibility for their health and wellness.
- There is a need for a review of medico-liability, which stops doctors from accepting responsibility for teams.
- The fee-for-service model restricts the way services can be delivered and which services are available from a specific practitioner.

Educating the population to share responsibility

It was considered that the following ideas would assist in achieving a literate society that takes responsibility for wellness at the individual and community levels. A concern was raised that in Indigenous communities people may not be as literate and may be afraid to speak up. There is therefore a need for different approaches and for ensuring that every health worker has training in promoting prevention.

It was suggested that there is a need to train all the population in first aid and promote the volunteer model. Having someone who can help limit the damage has huge benefits for the individual and the health system impact. This needs to include mental health first aid and what to do in situations where there is a concern that someone will self-harm.

IDEAS

- 5.27 Measure citizens' wellbeing as a health performance indicator and report it, to hold governments accountable.
- 5.28 Doctors should be funded to educate for prevention, first aid, wellness and chronic diseases.
- 5.29 Initiate a gap year for the health and community sector, allowing young people to experience the health system and how it supports the community. This could include placements in an aged care facility or with other community-based care providers.
- 5.30 Train Australians in first aid and mental health first aid.

Teamwork

The group felt that medical practitioners need to work in teams, where a range of nursing and allied health practitioners support the new treatment modalities and deliver a diverse range of care.

Delivering a team-based model of care would require changes across the current health system, as captured in the following ideas.

IDEA

- 5.31 Develop and deliver a team-based model of care.
 - 5.31.1 Change legislation to support a team-based approach to health care.
 - 5.31.2 Remove the barriers between Commonwealth, state and community care services and vest legal identities in group care teams.
 - 5.31.3 Change funding models to remove current barriers and facilitate team-based care delivery.
 - 5.31.4 Establish data sets on patient outcomes that enable decisions on the most effective means of treatment for the best patient outcome.
 - 5.31.5 Deliver team-based care through a new model of service delivery, one that incorporates the community, general practitioners, aged care, childcare, after-hours care—one-stop shop.

The right people to do the right job

It was considered that workforce planning needs to be more focused to ensure that Australia has the right people to do the right jobs. There is a need to be able to work out how many and what type of health workers are needed for 2020.

In considering workforce planning, the group canvassed the following:

- Taking into account lead times, a model should be developed to guide where additional undergraduate places are needed.



- Australia needs more generalist-trained doctors, but that they should be able to upskill in specific areas of interest or need—similar to general practitioner proceduralists, but with more options.
- We need to match people and jobs better—too much specialisation—and we need more teamwork. We might need more physician assistants and nurse practitioners with competency-based training. We need generalists that can be moved around the system as needs change.

IDEA

5.32 Develop a model to guide where additional undergraduate training places are needed to support the health workforce.

Using technology

It was considered that the future workforce would see nurse practitioners as being at the forefront, supported by the general practitioners and accessing specialist support via e-health in rural and remote areas. Virtual consultations would be widely available. In considering this, the group discussed the following:

- We need to change how we work—e-health—and we need incentives to improve uptake and access. We need incentives, not necessarily monetary, to get people to work in rural and remote Australia.
- Broadband progress will enable this but will need to be robust to avoid local problems.
- Electronic health records are now being trialled to enable information flows between hospitals and general practitioners.
- Dealing with service delivery in rural and remote areas will require changes in practice to enable timely service delivery through use of IT systems and enabling nurses and others to prescribe and order tests.

IDEA

5.33 Develop incentives to improve the uptake of e-health.

Training the next generation of health care workers

The following issues were raised:

- ‘Health care teams’ should be educated from university on, to ensure students are used to working this way from the beginning. There is much duplication at present, and the system could be made more effective.
- Access to clinical placements is now at a critical point: the number of trainers is declining. There is a need to provide clinical training in the community and not just in hospitals.
- There is a need to change the model of education and move to a generic health degree with specialist training that can be delivered centrally and flexibly, is competency based, and links to a registration system.
- There is a need to be cleverer about how we train the medical and nursing professions. At the moment retraining is extremely difficult and can lead to people walking away.
- There is a need for common accreditation and registration for all health professions.

IDEAS

- 5.34 Develop a model to deliver clinical training for the health workforce in communities.
- 5.35 Develop a generic health degree.
- 5.36 Develop and implement a system of common accreditation and registration for all health professionals.

Legislation to enable changes

In considering the legislation that is needed, the group canvassed the following:

- Legislative barriers should be removed to allow people with the right competencies to deliver specific services. We need to look at prescribing rights for non-physicians—for example, allow physiotherapists with appropriate qualifications to prescribe from a limited range of drugs for which they are qualified.
- Under a team-based approach it is imperative teams have a medico-legal identity. Present insurance would not be able to operate in a formal team structure.
- Currently legislation governs what physicians do and the Medical Benefits Schedule funds what they do. Examine the legislation. Can we provide incentive payments?
- We need a unique identifier for each patient for this to work. Medicare is to go live with this in 2009. Further information is needed.

IDEA

- 5.37 Examine prescribing rights for non-physicians—for example, allow physiotherapists with appropriate qualifications to prescribe from a limited range of drugs for which they are qualified.

Retention

The group discussed whether 'job redesign' could assist with retention of the health workforce—in particular, job redesign to make the most appropriate use of the highly skilled medical workforce and provide support to deal with the administrative needs. One participant raised the question of whether practitioners could be remunerated to provide lectures in schools or to community groups.

IDEA

- 5.38 Remunerate health practitioners to provide lectures in schools or to community groups.

Overseas-trained doctors

It was suggested that every overseas-trained doctor should be a physician assistant unless fully registered with an Australian state. One participant questioned whether there should be a transition year for these doctors. It was also suggested that developing a competency-based education and training system would enable overseas-trained doctors to fit in easily to gain competencies.



IDEA

5.39 Develop a competency-based education and training system for overseas-trained doctors.

Health, ageing and wellness: alternative models

The group felt that health care teams should support ageing in place. A major issue is how personal care is going to be delivered in the future. Frail older people need people to deliver their care. We need to look at how we train and how much we pay them. Currently many are from overseas, non-English speaking and with no training.

An alternative approach is to train up teams for such purposes—for example, keeping someone older and frail at home delivered by appropriate workers, funded horizontally, unlike current funding silos. Vertical funding should be removed. Use a capitation or block-funding model.

IDEAS

5.40 Undertake a review of the training and funding of aged care workers.

5.41 Train specialised health care teams to care for older people in the community.

Funding for future service needs

In considering the future funding of services, group members raised the following:

- There is a need to be able to fund evidence-based non-surgical alternatives. This could occur through a structure, similar to that of the Pharmaceutical Benefits Advisory Committee, that could approve these alternatives.
- There needs to be a mechanism for removing services that are no longer cost-effective.
- Cost savings will be derived through better use of resources and focusing on prevention to reduce hospital admissions. Further savings will be derived by allowing competency-based non-GPs to treat and prescribe within the extent of their competence.
- Consumer-focused treatment means moving past current funding models to enable the best mix of services for the individual in the most cost-effective way.
- There is a need for a hospital benefits schedule. This could include equity issues and remove the state–Commonwealth divide.
- Move to a single funder, but be careful of the impact on rural and remote hospitals.
- The Medical Benefits Schedule could be reviewed to reduce the need for visits to the GP for repeat scripts.
- The Medical Services Advisory Committee and Pharmaceutical Benefits Advisory Committee models have been very effective. Could similar bodies be developed that look at effective treatments and recommend whether they should be funded?
- Perhaps funding should be allocated to areas and not to practitioners. Could other funding models, which get away from fee for service, be examined?
- Aged care is not financially viable in the current system. Nurse practitioners could be the answer under the supervision of a doctor, but they should not have access to the Medical Benefits Schedule.

- There is a need to fund chronic disease management on the ground, which needs to be team based. Changing fee for service to allow for episodic care should be examined, as should different funding models for chronic disease management.

IDEAS

- 5.42 Develop a mechanism to examine the evidence for non-surgical treatments (other than medicines) with a view to funding cost-effective treatments.
- 5.43 Develop a mechanism to examine the evidence base of funded treatments with a view to removing services that are no longer cost-effective.
- 5.44 Review whether savings would be generated by allowing non-GPs to treat and prescribe medicines within the extent of their competence.
- 5.45 Develop a hospital-based schedule similar to the Medical Benefits Schedule.
- 5.46 Move to a single funder of health in Australia, taking care to minimise the impact on rural and remote hospitals.
- 5.47 Review the Medical Benefits Schedule to examine the need for GP appointments for repeat prescriptions.
- 5.48 Examine whether health care funding should be allocated to areas and regions rather than fee for service (that is, a fund-holding model).
- 5.49 Examine whether nurse practitioners could support health care provision in aged care.
- 5.50 Examine different funding models for chronic disease management—for example, episodic care funding.

Development of national outcomes data to drive resource allocation

- Slash red tape and stop collecting non-essential data. Get better outcomes data to drive resource allocation; note the example provided earlier of physiotherapy instead of surgery.
- Current resource allocation is based on systemic inputs. We need to *shift* the evidence base to focus on patient outcomes so we do not perpetuate the existing workforce but move to a responsive database.
- Change the evidence base from systems evidence to patient-, citizen-, community- and population-based evidence.
- There is a terminology problem because the use of ‘evidence based’ means clinical treatment regimes. Use the term ‘evidence guided’. Evidence shows that multi-disciplinary teams are the most effective way to manage chronic disease. This needs to be through regional funding authorities.
- We need a single funding authority for prevention and primary care at the regional level. This can fund the multi-disciplinary teams. We need pilot programs to encourage innovation.
- Build evaluation programs that report on what works and what doesn’t.
- Establish centres of excellence to use as training sites and to implement and trial new models of care.
- We need to fund health systems research; this could be combined with a centres-of-excellence approach, with working sites making use of innovative models.



- Move to evidence-based policies to support closing the gap with a funding model that is flexible enough to support evidence-based allocations.

Building the next generation of health workers

- We need the people to deliver the services: otherwise there will be no health service in 2020.
- If we want a healthy nation, let us be self-sufficient in producing our own health professionals. We need to develop a workforce that delivers the right care to the right people by the right professionals. The absence of doctors, nurses and health professionals in rural and remote Australia is a huge problem.
- We need to factor in the lead-time to produce professionals.
- We need to consider doubling the number of medical students *now*. Could we upskill the defence forces to assist in the health workforce crisis? This would also assist in meeting international aid situations.
- The number of medical students has recently doubled, but training places are now a barrier. We also have an overseas aid budget: could we partner with regional partners and build hospitals that can train both our students and theirs?
- The future workforce will look very different and needs a different legislative base. Changing the workforce will build a tiered health system that looks very different.
- Australia needs a flexible, generalist, engaged community-based health workforce providing the right care at the right time and the right cost.
- We need an interdisciplinary approach coming from a nationally accredited training system.
- Maybe a gap year system to engage school leavers in the health workforce.
- Remove legislative barriers to competency-based practice.
- A major issue concerns specialists: training them is complicated. We need to engage the colleges. Bring in competitive training models for specialists.
- We need to effectively evaluate and implement what is shown to be effective with the mechanisms in place to allow roll-out of these ideas.

The group came up with further ideas to build the next generation of health workers:

IDEAS

- 5.51 Develop nationally accredited, multi-disciplinary, competency-based modular training for health professionals supported by an appropriate legislative framework.
- 5.52 Consider doubling the number of medical students or upskilling the defence force to assist with workforce shortages.
- 5.53 Mandate minimum staff levels that are achieved by 2020.
- 5.54 Change what a specialist does so they only look at the most complex cases and provide advice to treat the less complex.
- 5.55 Develop and deliver community education on the role of the medical workforce.

- 5.56 Consider offering mature workers a 50 per cent salaried position and allow them time for education, training and research.
- 5.57 Consider training older people into the health workforce.
- 5.58 Improve support for health workers by providing administrative support that allows them to do their job and reduces red tape.

Out-of-the-box ideas

The group agreed on the following out-of-the-box ideas.

IDEAS

- 5.59 Health literacy for all Australians, including first aid for all Australians and how to help friends who are self-harming.
- 5.60 Healthy food leads to healthy nations. Model of food labelling (traffic light), label all food ingredients including trans-fats.
- 5.61 Develop a wellness rating scheme for all suburbs, towns and cities.
- 5.62 Establish a new preventive health strategy across life, with a major focus on Indigenous Australians.
- 5.63 A health impact statement for all new legislation and health impact studies across all portfolios.
- 5.64 A Health Equalities Commission, to be a high-level, 'with teeth' think-tank. Involved in monitoring, not delivering, services.
- 5.65 Organ donors: instead of opt in, make it an opt out option.
- 5.66 Promote better translation of Australia's health research into both commercial and health outcomes underpinned by increased investment in research and development.
- 5.67 A substantial increase in private research and development.

Three big ideas

IDEAS

- 5.68 A National Preventive Health Agency, based on the VicHealth model (to be funded through taxes on cigarettes, alcohol and tobacco):
 - 5.68.1 physical activity every day—30 minutes throughout the workforce
 - 5.68.2 kitchen gardens in schools to enable school children to see how food is grown and experience truly fresh food
 - 5.68.3 funding through taxes on cigarettes, alcohol and junk food.
- 5.69 An ASEAN-type collaborative health agency, including all regional neighbours, to address infectious disease, climate change–driven changes in disease patterns, and mental health.
- 5.70 Development of national outcomes data to drive resource allocation.



GROUP 3: ADDRESSING HEALTH INEQUALITIES

Equivalent health outcomes for all Australians

The group agreed they would like to achieve a healthy country where there is equivalent access to excellent health care for all Australians. There was agreement that a priority target should be closing the gap in life expectancy between Aboriginal and Torres Strait Islander people and the wider Australian population. It was acknowledged that it would not be possible to give every Australian exactly the same service but that it was vital to ensure that health outcomes (measured by mortality, morbidity and indicators of wellness) were equal and that there would be different methods and services to achieve the outcomes.

It was agreed that a range of issues need to be taken into account, including access and services and population diversity, and that outcomes are cross-portfolio and not just health (for example, for those in rural, remote and outer metropolitan areas); transport is inextricably linked to health issues. For Aboriginal and Torres Strait Islander people, improved education and housing is likely to improve health outcomes as much as, if not more, than any direct involvement in health services. It was suggested that there needs to be 'health proofing'—that is, to ensure that decisions made by government in other portfolios do not adversely affect health services and outcomes and vice versa.

It was noted that the determinants of health are not only found in the health system, but in areas such as housing and transport, education, social services, and that services in these areas need to be properly funded to help tackle all the determinants of health—for example, improving public transport in outer suburban areas.

The group felt it was important in determining health services to consider the diversity of the community and that there were many different views of what 'health' means, what being healthy comprises, and what is realistic to achieve in terms of health outcomes. Also raised was the need to consider the impact health services can have on people with disabilities or who suffer chronic conditions. These people must not be disempowered in any health decisions.

Adequate health providers

There was consensus that there needs to be sufficient funding for health providers (remuneration) and to train enough new providers to properly meet the needs of all communities—for example, culturally and linguistically diverse communities and rural and remote and outer suburban areas. This was considered particularly important in areas of high health need and it was raised that Aboriginal communities are often in areas of high health need and often, the best people to train and work in these areas might be Aboriginal people. Also raised was the importance of ensuring high-class education and training of providers. This included training to ensure they were competent in whatever community they were working in and this was particularly important for those who might work in underserved or underprivileged communities.

Related points were the need to provide a work environment that will attract people to the health profession and the importance of providing social support for health professionals, particularly in rural and remote areas. It was noted that providers don't or won't want to go to rural and remote areas if there are not other adequate services and facilities, such as educational facilities for their children, and that these services also needed to be considered by governments.

Other points raised were as follows:

- Efforts must be made to get more health professionals into the health workforce to stop the 'one person working 24 hours a day, seven days a week' syndrome.
- Establish a second tier of providers (non-traditional) such as those who could take blood pressure readings, and so on. This was countered by discussion that many nurses were not in the workforce, that more needed to be done to bring them back and that it was more important to retain the health workforce that the country has, not create another stream within it. Connected to this was a point that the number of radiographers in Australia was falling, and efforts were needed to provide the infrastructure to train new ones.

Rationalising governance, management and funding of the health system, including research

Consideration was given to improving efficiency, providing funding for outcomes and providing rational allocation of resources. There was consensus that the governance of the health delivery system needed to change and that it was vital to rationalise governance and management and the way services are budgeted. Health resources should be allocated to meet identified needs in communities across the country. It was noted that there were seven governance systems with 10 000 administrative staff. The system was dysfunctional and there was much duplication of services, while at the same time there was not good information exchange or effective use of technology. A point was raised that so much money was invested in Medicare without the evidence base and that some of this funding could be redirected.

It was agreed that the system must be patient centred and it was important to empower individuals and communities and to provide them with tools to help achieve this. Other points raised were:

- Ensure that engaged and informed individuals are involved in health and wellness and devolve responsibilities to communities.
- Cascade health professionals into organised teams as appropriate.
- Ensure that safety and quality are measured by the experience of consumers. This was particularly important for those suffering chronic conditions and disabilities: their experiences of the health system were not properly being considered when determining health outputs and outcomes.
- Often health service providers spend valuable time doing work that should be done by others (for example, administration), and this needs to be addressed to ensure that the providers can focus on their core business.

A person- and family-centred health system, collaborating across disciplines

It was considered that there is a need to understand the needs of consumers, that consumers have a good experience of care and that there be outcomes-based measurement. There was agreement that health service providers needed to be better attuned to the needs of the patient; to see a patient's illness or problem through the patient's eyes, and to treat the patient, not the disease or illness. Health service providers need to make the paradigm shift to focusing on the person and their care and not on health as a service they provide.

It was raised that performance indicators should be measured on outcomes based on the patient's experience of the care received. This should apply to primary and tertiary care. Australians need to be 'incentivised' and literate in their own health. This was considered important, as it was likely that only a minority of people were truly literate in the language of the health system.



It was suggested that preventive health care needs to be embedded in communities. There is a need for much more education within communities to help them help themselves with regards to preventive health care. One example covered was heart disease. It was easily prevented by changes to lifestyle, but currently there were not enough incentives for people to make the changes needed. It was also noted that some people just don't know what to do to help themselves.

There was discussion that incentives, including financial ones, may be needed to encourage lifestyle changes—for example, to give up smoking or drugs. Other points included adopting successful interventions from overseas. An example raised was from Norway, where people from communities are supported to help themselves.

Another idea not directly related to preventive health care but considered useful was to provide medi-hotel accommodation instead of remaining in a hospital bed for the last one or two days of the average hospital stay. This would be cost effective and would ease pressure on the hospital system.

A system focused on prevention

The group canvassed the following issues in relation to preventive health:

- Targets in health care are often too lenient and there should be zero-tolerance stretch targets. An explanation was given of a successful project in Sweden, where the road toll was lowered by only changing the target.
- The focus should be across all people and all areas of government.
- Use opportunities from major life events. It was noted that there are certain times over the life cycle that people are more motivated to change—for example, women during pregnancy and when breast feeding—and that those times should be targeted for preventive interventions.
- Another idea raised was better management of infection control in hospitals by removing all carpets and installing negative ionisers.

A system that prioritises health and wellbeing in the early years (from conception to adolescence)

There was acceptance that, although a life course approach to health is appropriate (recognising that events at all stages in life can affect events later in life, and even in subsequent generations), the critical importance of the early years of life warrants that strategies to improve health, development, education and wellbeing in this period become a priority for all sectors (health and other). There is now good evidence that the years from conception through to age 5 set a pattern for the rest of life. Most causes of mortality and morbidity in later life have their roots in these early years, and negative experiences (ranging from exposures to toxins and infections through to emotional abuse or neglect) early in life can result in permanent damage to the child. However, experiences in health, education and socialisation in the school-aged years are also critical and should not be ignored. It has been well documented that an investment in health and wellbeing in the early years results in a net financial gain to society, whereas the benefit of investment in adulthood is substantially less.

It was also noted that the relative benefits of strategies to improve health and wellbeing in the early years – strategies that may include improved family planning and antenatal care, better delivery services, improved parenting, methods to improve cohesiveness of families and communities, access to high-quality early childhood education – will have the greatest impact for people with the worst health outcomes. Therefore, there was agreement that priority for these strategies should be given to Aboriginal and Torres

Strait Islander people, refugee groups, people with disabilities and other groups of high need as identified through indicators of health and wellbeing.

An open sharing of health information

The discussion covered the value of being able to link health records over life. It was noted that there were 25 different health record systems and was it even possible they could be merged? Two suggestions were to use to a Google health initiative or to follow Denmark with a universal number.

Becoming world leaders in the development and use of technology and research

The following issues and ideas were raised:

- that research is valued. It was agreed that Australia should be a world leader in the development and use of technology and that we should be recruiting the best into the field
- recognition and promotion of a research culture. There was agreement that the health system had to embrace technology and about the importance of closing the gap between science and technology. All health departments should have a champion for research, and there should be networks established to ensure collaboration and interdisciplinary dialogue
- that health research is evidence based
- that research recognises the needs of consumers. There should be more rigour in what was researched and there should be more consultation between the National Health and Medical Research Council and the Consumers Health Forum to determine research that would be valuable for communities, although there was general agreement that there should be more focus on researching population health.

It was also noted that some incentives were provided to those who do the research, but not enough funds were provided to translating the research outcomes into practice. It was a 'fragile funding system', where researchers were not confident that their work would continue to be funded. It was also noted that, while funding might be sufficient for a young, single researcher, it was insufficient to sustain a researcher with a family and that was a reason why some researchers gave up the profession.

Rationalising governance in research was also raised. The research infrastructure varied from state to state and this should change to provide the necessary infrastructures to conduct useful research around Australia.

Having a rapidly responsive health system to deal with emerging global health issues

There was much discussion of the impacts of climate change on health. Carbon emissions are rising and the world is experiencing regular traumatic climate-driven events. It was felt that in this environment Australia will need a very different health system to respond to these issues, and it is not clear that the country is prepared for a mass deployment of people to respond to a major climate-induced health emergency. To this end it was agreed that support be given to communities to help prepare and strengthen their ability to deal with an emergency.

It was agreed that, by 2010, 50 per cent of the population would be trained in first aid and that, by 2020, 100 per cent would be trained. Training could be carried out by volunteers, who would go to schools, into the communities, and so on.



The following ideas were identified in the 'Ambitions' session but were not further developed in the 'Ideas' session.

IDEAS

- 5.71 Support communities to prepare and strengthen their abilities to deal with health emergencies.
- 5.72 By 2010, 50 per cent of the population be trained in first aid and, by 2020, 100 per cent would be trained.
- 5.73 Rationalise governance in research to provide the necessary infrastructures to conduct useful research around Australia.
- 5.74 Improve consultation between the National Health and Medical Research Council and the Consumers Health Forum to determine research that would be valuable for communities.
- 5.75 Investigate successful preventive health interventions from overseas and consider incentives, including financial ones, to encourage lifestyle changes—for example, to give up smoking or drugs.
- 5.76 Performance indicators should be measured on outcomes based on the patient's experience of the care received.
- 5.77 Cascade health professionals into organised teams as appropriate.
- 5.78 Establish a second tier of providers (non-traditional) such as those who could take blood pressure readings.
- 5.79 Better manage infection control in hospitals by removing all carpets and installing negative ionisers.
- 5.80 Establish zero-tolerance stretch targets in health care.
- 5.81 Provide medi-hotel accommodation instead of remaining in a hospital bed for the last one or two days of the average hospital stay.

One big idea

The group agreed on one big idea.

IDEA

- 5.82 Establish a Health Equalities Commission.

A Health Equalities Commission would address health inequalities across the health system. The first priority would be to reduce the 17 year gap in life expectancy between Aboriginal and Torres Strait Islander and non-Indigenous people and initial efforts should focus on improved health outcomes in the early years of life (including providing antenatal care to all Aboriginal mothers starting in their first trimester and continuing through delivery, providing continuity of health care in the early years of childhood, and focusing on preparing children for schooling).

The proposed commission would:

- be accountable to the Prime Minister or to the Department of the Prime Minister and Cabinet
- have the authority to enforce its decisions. This includes ensuring that through the Australian Health Care Agreements, the states have performance indicators relating to removing inequalities; that departments report back against benchmarks set by the commission, and that it can conduct investigations and report back to government

- develop a funding model to be based on the need to address disparities in health and wellbeing
- define where health inequalities lie. The commission would create a broad definition of 'health' to include indices of remoteness, social inclusion, cultural competence and function. All affected groups would be included. The initial focus will be on Aboriginal and Torres Strait Islander people, but other groups with unequal health outcomes, potentially including people with disabilities, the elderly, people living in rural and remote settings, would subsequently become priorities of the Commission.
- work with the National Health and Medical Research Council on strategic research targeted at measuring and reducing health inequalities. There was the view that Australia should spend at least the OECD average on research and development
- implement a task force as an initial activity, dealing with Aboriginal and Torres Strait Islander health inequalities.

Discussion of the proposal also included the following:

- The Commission should take a whole-of-life-cycle approach to addressing health inequalities.
- The health system should be defined so that it is properly connected to health and wellbeing. It needs to assess where and how all people fit into the system (for example, people with disabilities), noting that services are not well designed to help people with disabilities or those who are disadvantaged.
- Access is a key inequality, and this occurs across age groups and is often connected to lower financial status. Examples of groups that can suffer lack of access are young people, children from disadvantaged families, Indigenous people, people in remote, rural and outer metropolitan areas, migrants, and older people. It was noted that the more remote community, the higher the costs. It was also noted that Western Australia has a remoteness index that helps to identify disparities.
- Some of the inequalities are also around how health is funded. It was suggested that Medicare is now a pro-rich system and that the Medicare safety net needs work. It was also noted that Medicare is under-used by Aboriginal people and that work was needed to close the gap on the differentials.
- Any new health financing model needs to address inequalities. The current top-down funding approach often leads to funding being diverted to interest groups. A bottom-up funding approach should be considered, with per capita funding for everyone. Needs should be accessed at a regional level and funds should be allocated accordingly.
- A point was also raised about managing Aboriginal health services. It was noted that every time the government changed, management of Aboriginal health also changed. It was suggested that the states should be removed from managing Aboriginal health with responsibility being with the Commonwealth.
- It was also noted that more resources may be needed for particular groups (for example, people with disabilities) to help them not only with care but in achieving quality of life and wellbeing.
- The health workforce should be developed according to community-defined need. IT needs to be clinically and culturally competent and have the capacity to service different groups.
 - There should be universal health insurance but it should be funded according to need. It was noted that the data is available to do this.
 - Health should be included in all policies across government, and the Minister for Health should be responsible for ensuring this. One idea was that major portfolios include a health impact statement when planning policy.



- The commission could also deal with complaints in a more holistic manner than is happening currently. For example, it could consolidate issues so that if there were a number of complaints on one issue it would deal with the issue, not just the individual complaints.
- Members of the commission should be people from other health groups—for example, Indigenous Australians and people with disabilities. This point was also made and supported that relevant groups should be members or be head of agencies that affect them.
- The commission should identify specific equity groupings and advocate for more disadvantaged groups, such as the intellectually disabled.
- It should develop health and social impact statements on a whole range of issues.
- The group expressed the hope the government would set up a small working group to flesh out this proposal to assess its feasibility.

The other ideas the group agreed on were as follows.

IDEAS

- 5.83 The establishment of an opt-out system for organ donation, as in Spain.
- 5.84 The establishment of health literacy programs.
- 5.85 Oral health promotion to have a national approach and well-known interventions such as fluoridated water to be put in place.
- 5.86 The establishment of a health and education task force with the first priorities to identify risk profiles (those with chronic illness, disabilities, Aboriginal people, remote and the ageing population).
- 5.87 The development of a national primary health care strategy.

GROUP 4: FUTURE CHALLENGES AND OPPORTUNITIES IN HEALTH

A human-centric single health system focused on wellness

The group canvassed the following:

- Australia needs to change the way it thinks and to think creatively. A key idea is that we need to talk to the consumers.
- The health system should be tailored to the needs of the person, rather than jurisdictional funding requirements. There is a need for a human-centric focus.
- There should be a change of focus, moving from an emphasis on sickness to wellness. Fundamental change is required.
- The only way one can feed back to the health system is through a negative reporting system—when things go wrong. The system should allow a way of reporting positive outcomes as well.
- If we look at children and skin cancer, it is now socially unacceptable for children to play outside without being sufficiently covered or under shade. Smoking is no longer acceptable. This is about what we think we should be doing about our own health—what we have to do about our lifestyle. It is about doing something for ourselves. The emphasis is on collective responsibility along with personal responsibility.

- There needs to be a greater focus on prevention strategies (for example, tobacco use) where we can increase taxation while decreasing use. Care should, however, be taken with how strategies are defined, because a narrow definition may cause a different set of problems; for example, 50 per cent of people with mental illness smoke, so they would be targeted.
- In looking forward Australia is facing climate change and harm from alcohol and obesity. There will be further isolation of our rural communities and Aboriginal health issues. There needs to be an examination of what could be achieved by 2020. Technology will give Australia the opportunity to develop a health network throughout the country that will take these opportunities and run with them. Many services will be able to be provided via the internet. It will help us cut down isolation. It is about linking rural medicine with city medicine and sharing information and expertise around the countryside.
- There needs to be a focus on shared information, where patient records can be shared and each individual's information is gathered in one place. It was added that this was particularly needed in veterans' affairs.
- Australia only needs one health system. There are all these different systems around the country and a need for refocus. It should not matter where people come from, whether they are from one state or another: they just need to be fixed.
- There should be more focus on children and their future, so they are more aware of what they need to do now. From early teenage and school years, they need to be involved and engaged with education and training.
- But it is not just individuals. There also needs to be a wider focus on communities—on the children, on the elderly. It is taking seriously the dialogue with the community, and if you are serious about staying well we need to ask how does the community actually participate in staying well? It is not just about how health professionals advise them to stay well.
- We need more community involvement in health, where regional entities determine the needs of their region. A regional approach that focuses on the community, that brings together things such as Medicare, rural health. We need a different system: rather than state, federal, general practitioners, and so on, it has to be one system and community driven. It has to be one funding agreement. Abolish the states.
- It is about strengthening the responsibility of those in health. We need emphasis on a whole-of-government approach to health and we need government to be accountable for it. We should have health outcomes impact statements on all decisions taken by government. However, it is a whole-of-society, not just government, approach.

Measurement of outcomes and health practices based on evidence and outcomes

The group considered the following: 'By 2020 let us reduce the gap from what we need to know from evidence and use this to create incentives for wellness'. Participants raised the following points:

- Measurement should be conducted at a national level of key public health outcomes to determine what is being achieved. States and territories have been identifying health targets for years and they have extensive lists.
- It is not just about measurement, though: it is also about closing the health gaps. Evidence-based practice is needed. Areas that are not based on evidence should not be funded.



- The health system is always going to be seen as a cost. We need to change that and view it as a societal investment in health. It is about cost–benefit analysis: health produces economy-wide benefits. We have to have that entrenched in the way we view health spending.
- By 2020 we need to be considering investment by government in health care spending as an investment strategy rather than an expenditure strategy. We need to change our view and see it as investment for health gains.
- But we also need to reappraise that from time to time. For example, the Pharmaceutical Benefits Scheme: is it possible to determine if that investment is well spent?
- The health system needs to be sustainable, whether it is achieved through a percentage of our GDP being spent on health care or not. Spending on health needs to be reasonably targeted as economies grow people choose to spend more on health.
- The bigger question is where that money is going to come from: Individuals? Taxation? Private corporations?
- Everyone has to be aware that we have a responsibility for our own health. It has to be sustainable.

Productive ageing

In relation to productive ageing the following points were raised:

- There needs to be a focus on opportunities. The current focus on the costs of an ageing population is distorted; there are also opportunities.
- Abolish retirement. The concept of retirement should be replaced with the notion of older people moving to other forms of productivity, and they need good health to do it. We need a new concept in which they need some type of health vision to achieve. Retirement would go as a notion. We are talking about new and different styles of participation—new forms of work, new forms of contribution. We are definitely living older and are generally healthier.

A diverse workforce with new boundaries

Participants raised the following:

- We need to acknowledge that we have an ageing population and that its members are the largest consumers.
- The training of all health professionals has to be mainstreamed; we need a system that is much more orientated to the needs of the older generations.
- One of the things that underpins all this discussion is that we need to have an entirely different workforce to achieve those community-centric ideals. We have to start amending that now, to develop the types of jobs and system we want. We have to change the workforce. It will be a different type of workforce.

Research

The group considered the following: ‘By 2020 we will need to have a whole different health research system. It will need to be globalised and integrated across disciplines’. The following points were raised:

- The number of researchers in Australia is falling, and this is a problem. Australia should have a global health care industry, but for that to happen we need to have our own vibrant industry sector.

- Overseas much of the research is being conducted in national institutes of health. Those institutes have seen tremendous success, and health is not seen just as a health issue.
- Hospital-based research has seen a steady decline over the past 20 years. While we have an idea that research institutes and universities do relevant and beneficial research, hospital-based research, where care is delivered, is lacking. There is a UK-based model of hospital-based research that could be adopted.
- Health research needs to be re-focused across the whole sector, not just hospitals and not just research institutes but the whole sector.

The following ideas were identified from the 'Ambitions' session but were not further developed in the 'Ideas' session.

IDEAS

- 5.88 Establish a system of allowing reporting positive outcomes in the health system.
- 5.89 Measurement should be conducted at a national level of key public health outcomes to determine what is being achieved in public health.
- 5.90 Abolish retirement. The concept of retirement should be replaced with the notion of older people moving to other forms of productivity and for this they need good health.

The group considered the following themes:

- regional engagement
- workforce
- wellness centres
- preventive activity
- electronic health records.

After general discussion, the group agreed to a list of ideas.

Regional engagement

The following points were raised in a general discussion of ideas:

- We are very close to Papua New Guinea and Indonesia. We can learn something from the veterinarians, and the agricultural people. They learnt a long time ago that we needed to engage with neighbouring countries to safeguard our animals and crops, but we haven't learnt to do the same with human health. We need a national approach to dealing with dangerous pathogens—and not necessarily a physical structure; there could be a virtual way of dealing with this.
- A number of countries are crying out for help, particularly our poorer neighbours, not only in infectious diseases but also chronic diseases.
- We need to engage more with our geographical neighbours. For example, there is the World Organisation of Family Physicians and others that we could engage through. We have a low capacity in research and development, so we could develop links with regional partners to progress this. We can engage on various fronts—education, for example. We don't seem to capitalise on these opportunities very well.



- Could we have an equivalent of ASEAN but it's about health? We need a regional health leadership role. There is a new stream on health in APEC but it has only just been created. A health ASEAN should take a leadership role on health in the region, and we need to develop the health conversations between nations. Australia should take a lead role.

Workforce

The following points were raised in a general discussion of ideas:

- What will hit us in 2020? What will we have to deal with? It is the chronic conditions, heart disease, lung disease, and so on. How will the system deal with these issues? Mental health issues are increasing. Unless we deal with workforce issues, we won't be able to deal with these challenges.
- What sort of health professionals do we want in 2020? If we're talking about regional Australia, you're not going to get a specialist workforce outside city-based areas. What is it that we can do? What has to change so that we can have health professionals that can interact with city-based specialists for support (for example, nurse practitioners with prescribing capabilities)? What needs to change to overcome the stresses and challenges that they will face in 2020? A nurse practitioner that adds value to a general practitioner, intervening earlier and connected via broadband—'super-nurses' or 'super-paramedics'.
- We can't afford coronary disease. Technology is often inappropriately used. Cardiologists could cripple the system if we allow them to. There's a 'dumbing-down' of the system. We need training and investment in health professionals.
- One of the biggest battles we had in the last decade was the nurse practitioner: we were given all sorts of doom and gloom scenarios. But that isn't what has happened. What we've seen instead is that nurse practitioners have filled a particular need. University training will take years to get those people into the system, and in the meantime we're going to have shortages. Technology can enable you to provide an on-the-spot service: we need to use the basic technology, such as the laptop, better.
- In Australia one of the barriers is that every state and territory does things differently. We need to have one vision, and then we look at how we develop the workforce, and the other issues flow from there. We move from state to state and the waste of time with registration is considerable. We can do this better.
- There is a need for monitoring and intervention earlier to prevent the high cost at the end of the system. It's about making use of what is a mobile workforce now and adding to the skills of what we've got now. We're not going to get there in 2020 without dealing with what we need now.
- Practice nurses are an idea that is already there, already in existence. In New South Wales there are about 100 000 nurses. The workforce is there: it just needs to be tapped and exploited. There are some very positive outcomes from a small trial that uses two nurses as care coordinators for over 300 veterans. Perhaps we should look at these sorts of models more closely.
- There should also be some recognition of the role of carers and equipping them to better help manage health conditions. With an ageing population—which is also a population that takes up the bulk of costs—we need to train people to better handle their needs, thereby reducing the impact on the health system.

Wellness centres

Wellness centres should be in schools and local community centres. We need to develop a model that assesses wellness as we go. The following points and views were raised in the context of generating ideas:

- There is a Canadian program to help young mothers with children—early intervention by placing parents in parenting classes, while the child gets placed in care (not taken away) while mum is learning about how to become a better mother. The system is showing results. It is not a low-cost solution, but it is a solution.
- There are super-clinics in New South Wales where every mother of a newborn baby receives a nurse visit to assess post-natal depression and the baby's eyes, ears, and so on. Further follow-up is then conducted two weeks later. It is about wellness and constantly feeding into that—assessing people as they go. We could create, for example, integrated primary care centres.
- Part of the baby bonus could be tied to antenatal and postnatal parental training, including for Indigenous communities.
- There needs to continuity of care from birth to death.
- We could pull together existing services to construct a 'one-stop shop' for health and wellbeing. This has been done previously. We could develop a program now in five- to 10-year gaps that adopts a holistic approach.
- We could build wellness centres in shopping centres for older people, so that they can access all-in-one services. Day clubs and social clubs are good developments for older people, to encourage them to remain active and engaged.
- What we need is integrated health, wellbeing, and disability centres—regional hubs of wellbeing. Funding specifically for preventive services—we need a separate funding stream for prevention services.
- If we want to affect behaviours we need to stagger interventions in the earlier part of life. People put their money into kids, corporations put their money into kids. We need to target kids and take it from there.

Preventive activity

The following points were raised:

- We know what the five main killers are, but we're not focusing on them. There have to be incentives for general practitioners to spend time to address preventive issues. However, why does it have to be GPs only?
- Levy taxes proportionate to the damage they do—for example tax alcohol by its strength (proof)—to create a separate funding stream for prevention.
- What about workplaces? We could work on improving canteens, ensuring there are more stairs in workplaces to encourage people to avoid using the elevators. We need to design buildings and public spaces better to promote walking and exercise.
- Examine integrating health issues into education: create a mandatory health and wellness curriculum and program. Societal norms have changed and we need to redress them. A performance indicator for educators should be health improvement.



- We are moving to a stage where people need high-care provision in residential care. Suggest individuals contribute a percentage of their superannuation to residential care funds. Employers could also make contributions, and we could start building new high-care facilities with the funds generated by the scheme. We could also begin using hotels or step-down facilities to free up high-cost medical beds.
- One of the main things we should be ensuring is that healthy food should be cheap. We know in Queensland that healthy food is about 25 per cent more expensive than non-healthy food. That should be addressed.
- We have the technology now to create a 'carbon account' for individuals. We need to realise that if we buy oranges from California they have a carbon 'weight' attached to them. We need to look at models such as carbon trading. By reducing the amount of carbon we use, we get money back. However, we need to be equitable with carbon trading system and take into consideration lack of public transport infrastructure, and so on.
- We need to have a coordinated approach with organisations such as cancer funds and health funds that adopt targets and initiatives for five years as opposed to 10 years—a coordinated approach where all these organisations are working together under one boss and that has a coordinated clinical framework body, where they set measurable goals and targets.
- We need regionally integrated services and peak national bodies working to a common script. We need a nationally integrated strategy around health promotion and illness prevention, with the integration of organisations such as Centrelink. The disease management and prevention framework should be evidence based.
- Indigenous health: focus on clean water and housing; make clean water a public good, promote research and development on clean water; promote hand-washing campaigns.

Electronic health records

The following views and ideas were raised in relation to electronic health records:

- Consideration could be given to everyone having an individual electronic health record. They should have information and resources for people to make informed decisions; that, no matter where you are, you should be able to access it; and that you don't have to actually see someone in person to gain access to treatment.
- There are a number of tools and resources we need to build to enable us to do this. We could develop and implement an electronic health environment—one that will enable people to participate in their own health care. We could create a system just like Facebook, a 'Healthbook' where you need to have permission to access it. Individuals would choose whether to share their data with their family, friends or doctor.
- The Healthbook concept is not necessarily an agency-based initiative: it could be a social networking consideration. This is something that can be led from the community. Five years ago a web-based system was implemented in Walgett. It is already in existence, so it is not a 2020 issue.

Some participants considered that there would be difficulty in implementation and doing this over time. Systems of this nature have been attempted by Microsoft and by Google Health, where they extract clinical information. These are not covered by the privacy requirements, so privacy is not protected. The system needs to enable consent to be given and withdrawn. It was felt that the core issue would be control

of the information and where the control would lie. If people are going to share their own data there needs to be strong safeguards.

In further discussion these additional points were raised:

- The only information that is relevant is clinical information, capturing prescription, referral, discharge, and so on, and copying it to an individual record. There needs to be integrity of the clinical record.
- In about five years we'll be able to map our own genetic information and profile. If you have certain risk factors, the genetic information means you'll be able to intervene earlier. It is not so much to share your genetic information: it is so that people can take control of their own health.
- The core element is that it is a personal health record, not a patient record. The role of government is to make it accessible; the more dislocated you are, the more this sort of system is of importance.
- Healthbook is a web-based personal health record. It should be the person's individual choice whether they share this information. It should be able to include both clinical and experiential information.
- It should be controlled by users but validated by clinicians as appropriate. Authenticated and endorsed by government. Government would need to develop guidelines.
- There would need to be money on the table for this. It requires national infrastructure, and if it is a national system you need national guidelines and a national framework.
- If it is linked to prevention it will pay for itself.

Following these discussions the group agreed to a list of ideas.

IDEAS

- 5.91 A health 'ASEAN' for regional collaboration on infectious and chronic diseases and mental health, with Australia as a champion.
- 5.92 An Institute for the Future—smart communities for better health, forecasting emerging health challenges.
- 5.93 Research and technology for clean water in Australia and the region (in the face of climate change).
- 5.94 Integrated health and wellness centres, regionally based, for children.
- 5.95 A separate funding stream for prevention, funded by tax on alcohol, fat, and so on.
- 5.96 An individual e-health record, plus 'Healthbook' (like Facebook) to share health information.
- 5.97 Education scholarships for young people with mental illness, to enable re-engagement.
- 5.98 Joining up initiatives in early life (testing, intervention)—integrated primary care centres for children, regionally hubbed.
- 5.99 Incentives for prevention—employers, healthy food in canteens, exercise.
- 5.100 Designing healthier buildings and neighbourhoods.
- 5.101 Allow residents to contribute to high-care beds.
- 5.102 A hypothecated superannuation charge for aged care.
- 5.103 'Medi-hotels' to be built into hospital precinct planning, thereby freeing up funding.



- 5.104 Performance indicators and mandatory curriculum for health and wellbeing in schools, including the ethics of health care.
- 5.105 Gyms and social clubs for older people.
- 5.106 Personal carbon trading for better nutrition and exercise.
- 5.107 Training health professionals in caring.
- 5.108 Coordination of health and social services organisations: a national framework of targets, measures audited, with a regional focus.
- 5.109 An ecological health survey to forecast disease burden.
- 5.110 A national hand-washing campaign, including a hand-washing campaign in Indigenous communities to reduce blindness.

The group then discussed some of the ideas further and added the following points:

- health 'ASEAN'
 - focusing on shared challenges and addressing inequalities to deal with infectious and chronic disease and mental health
 - an ASEAN-like structure that operates at a high level across all developing and developed countries
 - Australia's contribution underpinned by consortium of Australian research, training and public health institutions to extend and coordinate existing individual relationships
 - a 'good neighbour' focus for day-to-day health needs, including aid
 - real expertise, pulling together virtually—the best
 - research and clinical minds from the region.
- 'Healthbook'
 - a web-based personal health record, that gives the user choice in who they share the information with
 - information about you for managing your health
 - controlled by users, but validated by professionals (as appropriate)
 - enabled by government
 - in future, may be able to buy and load a genetic profile to share with trusted health 'friends'
 - especially useful for Indigenous and dislocated communities, to ensure continuity.

An out-of-the-box idea

The group agreed on the following out-of-the-box idea.

IDEA

5.111 Health impact statements of all new government policies and an immediate audit of taxation for adverse impacts on health (for example, FBT—fringe benefits taxation on vehicle leasing that encourage more driving).

GROUP 5: HEALTH RESEARCH, RESEARCH TRANSLATION AND RESEARCH TRAINING

Key goals

1. The research agenda should be set to reflect the key health issues—for example, obesity and mental health (the '2020 Grand Challenges'). Research should involve vertical and horizontal integration (that is, be across disciplines).
2. The next paradigm shift for research involves ongoing leverage of Australian research in a global commercial environment, with a view to capitalising on intellectual property developed in Australia. Multi-national investment in Australian research is needed. This is seen as a no-cost idea and a major income opportunity to bring researchers back to Australia.
3. Restore and enhance the capability and capacity for clinical research as part of clinical and health services in teaching hospitals and across the health system more broadly.
4. Strengthen the interface between research and clinical practice to deliver better health outcomes by harnessing the opportunities presented by better knowledge of diseases in a more timely way.
5. The federal government should play a leadership role in a national, coordinated approach to infrastructure (indirect research costs and capital works) funding support.
6. By 2020 research will be recognised as a valued professional career path through encouragement of recruitment and retention.

Themes

The three themes the group identified for discussion were as follows:

1. *Research.* This included the appropriate structure to deliver research being based around achieving key 2020 health outcomes. While new ideas for research are important, it is also important to build on existing areas of research.
2. *Translation.* This includes across the areas of commercialisation and ownership of intellectual property; use in clinical treatment, health care services, health care systems and policy settings; and appropriate infrastructure funding support.
3. *Training.* This includes capacity building associated with research, including education, learning skills and working to ensure a career path in research.



Challenges

It was recognised that research with commercial outcomes and public good outcomes are necessary. The need for 'blue sky research' was also recognised, noting that this may also lead to a quality health outcome, although not directly linked to a defined outcome from the outset. Recognition that funding for research could not be solely driven by the number of patients affected was raised in this context.

A key issue identified as being critical is the need to bridge the gap in the research and development pipeline between the first stage of development and the commercialisation of research.

It was suggested that 'silos' exist in current training and that, while capacity should be built within particular disciplines, in 2020 it will be necessary to have greater ability for dialogue and integration across disciplines.

There was discussion about greater involvement of end users in all stages of research. Some group members raised the issue that end users may not always understand research issues, and this may result in the research being less effective. The link between recruitment and job satisfaction was noted as part of this, particularly the importance of research in the clinical hospital setting and the need for training. This was raised as of particular concern for some Sydney-based hospitals, and the group agreed that this is an issue nationally.

The need for cross sectoral and cross disciplinary research was recognised, as was the need for a cross government approach for investment in health. The group agreed this requires a more creative approach to achieve a common outcome. For example, addressing obesity may require significant input from agriculture.

Research

The need for sustained input into research was recognised by the group, and there was general consensus that a fixed percentage of GDP should be spent on R&D, aspiring to at least the OECD average, noting that bipartisan support should be sought.

It was suggested that current spending levels could be used as a benchmark, which would be cost neutral in being a commitment to current funding levels, not a request for additional funding. It was recognised that this would relate to overall R&D, not just R&D in the health sector, and that a further decision regarding an appropriate allocation from the health budget for health and medical research would also be required.

Once a fixed percentage is locked in, the best way to distribute funding was seen as being through peer review to deliver appropriate funding towards the research most required in, and across, particular areas.

Locking in a future level of funding is seen as different from agreeing that the amount of funding cannot be reduced. It was noted that setting the amount of actual funding tied to economic prosperity.

Research reflecting key health issues and involving vertical and horizontal integration

To solve key health problems, it was recognised that it will be necessary to move outside traditional 'health research' areas into, for example, aspects of lifestyle. It was suggested that having a 'research champion' in every health-related government agency at federal and state level could achieve a greater profile for and focus on health research.

The importance of evidence-based decisions as the basis of a good health system was discussed, noting that if research dwindled knowledge would also dwindle and this would reduce the ability to identify better preventive health measures. Good research was seen as giving the ability to fill preventive gaps with evidence based solutions, noting that research is never static.

It was recognised that the top of the 'house' being created through the summit was about health outcomes and that research is part of the process to achieve the outcomes. Articulating how research underpins the big issues for 2020 (for example, mental health) was seen as very important. Identifying key 2020 priorities and then setting the research agenda to deliver key health outcomes by 2020 was proposed. It was noted that research may show that some key issues identified are obsolete.

The group posed a question about whether in funding initiatives to achieve 2020 health outcomes research should be structured to include disciplines outside medicine (for example, the impact of dysfunctional families). An example was raised of the Aboriginal Research Cooperative Research Centre not employing researchers but playing a collaborative role and outsourcing the specific elements.

It was seen as crucial for research to be linked to a purpose through performance requirements. Capacity building for senior researchers and improved career paths for junior researchers were seen as important to achieving excellence and a better health system in 2020.

It was seen that, while there are currently good researchers in health, there is room for improvement in working across disciplines. Determining a way to cluster interdisciplinary research capability was seen as important.

Historical inbuilt physical, geographical and regional silos in the structural organisation of research were discussed.

The group agreed that vertical integration of science (from the lab through to population) on key challenges is needed. The connection between the generation of the research agenda up front and the translation of knowledge at the end (also linked to the doing of the research in the middle) was seen as an area that could be improved.

As noted, a clear goal agreed by the group was that a proportion of GDP should be established as dedicated funding for research and development. It was noted that the challenge is working out how best to spend the funding, given that knowledge generation and delivery into the clinical and business arenas are a continuum. The analogy of this continuum being a 'pipe with blockages' was discussed, noting the importance of identifying where current blockages are and working out how best to spend available energy and time in fixing the blockages and redesigning the pipe. It was seen that it might be best to throw out some ways of doing things in the historical system. Finding blockages and gaps was seen as the first priority to fix or, if the pipe is broken and there is no delivery occurring between systems, then this needs to be done better.

There was discussion about having national institutes for key issues such as cancer and mental health. The system in Canada was raised, and the group was of the view that this system is working well. It was noted that this is different from the 'pipe' system in Australia. It was seen as being outcome focused, with directed base institutes. In an Australian context there was some discussion as to whether this could be done under the National Health and Medical Research Council but ensuring that a range of input factors are brought together.



It was also recognised that the United States does this well, having institutes that are mission directed and get public support. In this way major health challenges are turned into a targeted agenda and instituted. One issue with this approach was that one discipline might receive more funding than another. It was recognised that this occurs now without the 'targeted institute' approach and that having a purpose-based objective to be achieved could still be beneficial.

One point of discussion is whether the US institute model is good because of its structure or because there is extra funding in the system. It was recognised that this approach could drive funding outside the government.

In the context of discussion on the value of the targeted institute approach, one model proposed was that end users should be included from the beginning in establishing the research agenda. This was seen as being beneficial, with end users seen as being able to drive the nature of the institute programs. For example, if there is a 2020 outcome to be achieved on mental health, then the end users who work in and are affected by mental health would be involved in that demarcated institute. This was not universally supported across the group.

In general discussion the group agreed that excellent research should be funded appropriately, whatever discipline it is in.

Translation

The next paradigm shift

Research is global, and it was recognised that an Australia-centric view should not be taken. Existing problems with linking domestically need to be addressed before we can effectively link globally. It was recognised that Australia needs to be part of international research community and that every opportunity should be taken to link better with the emerging scientific powerhouses of India and China.

It was recognised that the focus of the Health stream of the 2020 summit is health outcomes for Australians. While research is global, we need key learnings in an Australian context which can be used to provide influence and collaboration outside Australia.

The group recognised that the level of government funding for research and development in Australia was comparable to OECD standards and that the big gap was in the private sector research and development. This was seen as also having an impact on the lack of solid career opportunities for researchers in Australia.

In discussing how to get increased research and development funding in Australia by multi-nationals, the group felt that if this could not be achieved by companies establishing research activities in Australia, then at least having them contribute to a fund to help government support excellence in research was seen as an option. It was agreed that this constitutes a form of taxation and was suggested that it be placed into an R&D endowment fund.

Achieving effective translation of research was not seen still to be inadequate. The group agreed that there are significant gaps in funding for early development. Greater ability to commercialise research was also seen as a way to improve the career structure in research.

There was extensive discussion on the concept of 'angel investment' by reference to the United States, where start-up money is more readily available, which helps to avoid research outcomes falling into the 'valley of death' in which the opportunity to commercialise the research is lost. It was agreed that this is

not just about funding; it is also about mentorship to address the gap in the middle between initial research and a fully commercialised outcome.

The group indicated that currently government invests half a billion dollars in base research and proposed that government funding be made available to work up propositions to put to private industry to get the end result of commercialisation. There was a suggestion that the Future Fund invest in this.

The need for government recognition and investment as seed development funding to support the proof of principle research was seen as very important. The group suggested that \$100 million a year could bring about 250 commercial opportunities. It was also agreed that this support could not be just another pre-seed fund as the issue is not just money. The way intellectual property is developed and then frequently lost from Australia needs to change.

An example of cancer research in the United Kingdom was discussed as a good concept. Funding is provided by Cancer Research UK and commercial development oversights by its subsidiary Cancer Research Technologies.

The group discussed the cervical cancer vaccine created by Dr Ian Fraser, there being some disagreement as to the degree to which this was ultimately commercialised off-shore.

There was some difference in the views on seed funding, with some viewing this as supporting the interaction between basic science and small clinical trials driven by the excellence of the discovery. Other members of the group were of the view that current seed funding provides the opportunity for researchers to take 'time out to progress bad ideas' and that this funding is not being used effectively. Building a stronger government link between the funding and what is done with it was seen as worth exploring.

It was suggested that government support to stimulate 'angel investment' would not require significant additional funding as current approaches for seed funding could be replaced with this new approach. Angels would bring both money and act as mentors, which would assist with the current failure to get commercial skills in research. The group generally agreed that this should not occur for drug research because of the long lead times required, but are more appropriate for devices.

A key step was seen as being able to better manage the intellectual property we generate. Once that is achieved, then there are various routes to translate the research, which requires skills, not just money.

The view was put forward that universities have expert transfer offices to assist in commercialisation, but that smaller institutes cannot afford to have this expertise available. Structuring funding and research around generating critical mass for commercialisation was seen as important. It was recognised that universities are developing commercial arms and that money is coming back to these universities through this process that is then available to further research. It was also recognised that even at expert places, income generated from commercialisation was a very minor proportion of total funding.

The importance of sustained investment in research over a long period of time (noting the UK cancer model has now been in operation for 20 years) to address health outcomes and meet commercialisation needs was stressed.

By 2020 the group wants to see greater success in commercialisation of health and medical research. This will need improved entrepreneurship, management and funding mentorship. The group agreed that government should balance investment in base research versus commercialisation support to get a return on investment through commercialisation. This was seen as the next paradigm shift.



How to attract multi-national investment in R&D into Australia was the subject of much discussion, with direct investment and a tax to be put into a dedicated fund being discussed.

The Australian Research Council Business Linkage grant to small R&D private companies was seen as a good model, with one example of encouraging a link between a pharmaceutical company and a university veterinary school which has had a positive outcome for both raised.

If early seed funding could be provided through the business sector, possibly through the Business Council of Australia, then this could be at no cost to government.

By 2020, the group wished to see big improvements in the translation of new knowledge into changes in policy and health services.

Restore and enhance the capability and capacity for clinical research

The group agreed that teaching hospitals have lost all support for doing research with research now just occurring in universities and institutes.

A creative research environment was seen to be a very positive factor for recruitment of high quality health care personnel, particularly for teaching hospitals. Good teaching hospitals were seen as critical by the group noting that, for those starting medical school and also commencing a career, understanding a medical career, research is of great importance to them.

Restoring and enhancing the capacity for clinical research in teaching hospitals and health systems was seen as critical for introduction of new evidence-based treatments to the clinic faster, improve health outcomes and saving overall health costs.

The group agreed that teaching hospitals are now wholly focused on service delivery and not on clinical research, with no time to do anything other than deliver on the bottom line.

Current blockages are seen as including indemnity, stem cell research and Commonwealth–state tensions. There was general agreement that state health departments are concerned about risk in relation to human trials and that there is a strong need for greater reassurance in relation to risk. A national approach to ‘first in human’ trials was seen as one way to assist in this area. Encouragement of ‘first in human’ trials was seen as a very important mechanism for translating research outcomes into better treatment.

Strengthen the interface between research and clinical practice

The need for a good health care system to be underpinned by a good research system was a key area of focus. Lack of recognition of this in the public submission process was highlighted, with, for example, around 30 per cent of submissions focusing on the need for preventive health and only 3 per cent focusing on research.

The current system of ‘gates’ opening up in research being based on publishing papers was seen as a barrier in the current structures to achieving better outcomes across the health sector.

Getting research into practice was seen as a major blockage. The group was of the view that the people delivering health care are not receiving the outcomes of research. The group agreed on the importance of research in a teaching hospital, with the view that if a person is research trained and has that philosophy they will provide better treatment.

The group agreed that if Australia wants good health care outcomes in 2020, including the system to achieve these outcomes, then this must be underpinned by a good research base and research capacity. Knowledge gained through good research is critical because health and research are always evolving. To achieve health outcomes it was agreed that health services need to be based on a world-class evidence-based system that is constantly evolving.

Improved organisation of delivery of research outcomes was seen as critical for the group. Closing the gap in translation to reach the point of delivery is seen as necessary.

There was discussion about translation being more achievable if end users of research are involved from the beginning in setting the research agenda. Examples where this had worked in the Indigenous health space, with government and Aboriginal health services being involved from the outset, and also in research for hospitals, were put forward by the group. In essence, this was seen as organising research to inform outcomes to be achieved so that the agenda is set, and translation is assured, according to the needs of the end users.

Developments in knowledge around diseases are rapidly changing because of research, and many more opportunities and new ideas that could have positive outcomes for patients exist that are not being taken up in the current system.

Cancer treatment was used as an example: currently in hospitals there is no time to use the best available tests or the best available knowledge of which type of treatment best suits which patients.

The federal government to play a leadership role

The need for improved infrastructure funding (indirect costs and capital works) for health research was highlighted, noting a need for rationalisation of the multiple inputs across Australia. The US model, where indirect costs are directly attached to research funding was discussed.

Infrastructure funding was seen to be a state responsibility. The group sees the federal government having a key role to provide some consistency across jurisdictions through a nationally coordinated research platform for infrastructure.

Training

Research recognised as a valued professional career path

There was extensive discussion on improving the career structure in research, with the need for it to be better recognised as a 'profession'. There was also discussion of the lack of a clearly defined entry path, noting research was not recognised in the same way as, for example, law and medicine.

The importance of having the 'best and brightest' being more disposed to return to Australia and work here was seen as critical. Development of a more secure career structure for researchers was seen as a way of achieving this. The current lack of a clear career path was seen as an issue for retention of young researchers, with issues including ensuring job security and meeting changing demands for work-life balance to take account of family needs. The difficulty faced by current researchers in accessing credit for mortgages was identified, noting poor funding and lack of job security currently.

Public recognition of science was seen as critical. Promotion of science education in schools to increase interest in working in research was seen as important to ensure a solid research base into the future.



By 2020 the group is looking for research to be a profession with clear leadership and mentorship, with a professional body to drive it. There is a clear need for a shift in how we see research as a career path and not just as being tacked onto the end of a science degree. Well-established mentorship is seen as important.

Better recognition for research will encourage recruitment and retention, including retention of women at senior levels, which remains poor.

One big idea

The group was tasked with further refining one of the top ideas put forward from the voting session on the Saturday. Following discussion, the group agreed on the following improved wording.

IDEA

5.112 Promote better commercialisation of intellectual property, by taking the lead in developing innovative health technologies, such as inventing a 'bionic eye' by 2020.

The group expanded on this to include promoting better translation of Australia's research efforts into commercial and health outcomes, underpinned by initial public investment and supported by increased private and philanthropic investment in R&D.

This would be achieved by:

- building Australia's skills and capacity in scientific entrepreneurship and intellectual property management
- developing philanthropic partnerships
- significant increases in partnerships with industry
- integrating state and federal infrastructure funding—for example, the indirect costs of research
- financing and mentoring nascent health care and health technology companies
- national and international IT interoperability—computer systems using same language.

This is to improve the health of all Australians by 2020. Examples of aspirational goals include the bionic eye, more biotech companies the size of Cochlear by 2020, and new Australian treatments of illnesses such as type 2 diabetes, dementia and cancer.

Key points from the discussions on the Saturday that the group provided further comment on included the need for:

- more expertise in commercialisation and management of intellectual property, in order to progress translation—both commercial and clinical
- centralised and coordinated management of intellectual property across all areas
- a new way of thinking in delivering research
- determining what problems can be solved and how research to address identified problems can be made commercial—that is, choose a research agenda that will be commercially viable and that research institutions have the knowhow to deliver
- a research system that matches the scale of the importance of health to this nation

- sufficient investment in research infrastructure in Australia to use effectively any additional funds that come from multi-national or philanthropic investment, noting that if this is not available then overseas funding cannot be accepted. Government is seen as having a clear role to ‘match private sector offers’ to provide for appropriate infrastructure
- staged and sustained public, private and philanthropic increased investment in R&D, possibly including benchmarking with other major innovative commercially successful industries and growth in health R&D expenditure should be proportional to growth in total health expenditure
- leveraging off foundations—such as ‘Gates Grand Challenges’ in the philanthropic space
- recognition of the importance of global integration and interoperability.

Other ideas the group put forward in the session were:

- improving genomic diagnosis and treatment—for example, making gene space part of the ‘Healthbook’ concept
- all major Australian research institutions having responsibility to develop partnerships with Indigenous communities to build the Indigenous health and medical research skill base and focus research on addressing major Indigenous health problems.

Following are the group’s ideas.

IDEAS

- 5.113 A fixed percentage of either GDP or the health budget to be directed to health and medical research and development, aspiring to at least the OECD benchmark.
- 5.114 The research agenda to include the key health issues—for example, obesity and mental health. Research should involve vertical and horizontal integration (that is, be across disciplines).
- 5.115 Establishment of national institutes for key issues such as cancer and mental health. This could be done under the National Health and Medical Research Council but ensuring that a range of input factors are brought together.
- 5.116 Encourage R&D funding by multinational companies in Australia, either by establishing their own research activities in Australia or making tax contributions to a R&D endowment fund to help government support excellence in research.
- 5.117 Commercialisation of research:
 - 5.117.1 improving the commercialisation of research in Australia to improve the research career opportunities
 - 5.117.2 government seed funding being made available to work up intellectual property to the commercial ready stage
 - 5.117.3 government encouragement for funding for ‘business angels’ to support the early development
 - 5.117.4 that the Futures Fund invest in this with a figure of 0.5 per cent being raised to get base research to commercialisation



- 5.117.5 government recognition and investment as seed development funding to support the proof of commercialisation for base research. \$100 million a year could bring about 250 commercial opportunities. Government support to stimulate ‘angel investment’. This should not occur for drug research but would be more appropriate for devices. One option for delivering this was a grant scheme for translation
- 5.117.6 government to balance investment in base research versus commercialisation support to get a return on investment from commercialisation. If this involves the business sector, possibly through the Business Council of Australia, it could be at no cost to government.
- 5.118 Restoring and enhancing the capacity for clinical research in teaching hospitals and health systems was seen as a way to take new evidence-based treatments to the clinic faster, improve health outcomes and save overall health costs.
 - 5.118.1 A national approach to ‘first in human’ trials was seen as one way to assist in this area.
- 5.119 Strengthen the interface between research and clinical practice to deliver better health outcomes by harnessing opportunities presented by better knowledge of diseases in a more timely way.
- 5.120 Development of an improved career structure for researchers:
 - 5.120.1 Promotion of research education in schools to increase interest in working in research was seen as important to ensure a solid research base into the future.
- 5.121 Promote better commercialisation of intellectual property, by taking the lead in developing innovative health technologies, such as inventing a ‘bionic eye’ by 2020:
 - 5.121.1 building Australia’s skills and capacity in scientific entrepreneurship and intellectual property management
 - 5.121.2 fostering philanthropic partnerships
 - 5.121.3 integrating state and federal infrastructure funding—for example, indirect costs of research
 - 5.121.4 financing and mentoring nascent health care and health technology companies
 - 5.121.5 centralised and coordinated management of intellectual property across all areas
 - 5.121.6 determining what problems that can be solved and how research to address identified problems can be made commercial—that is, choose a research agenda that will be commercially viable and that research institutions have the knowhow to deliver
 - 5.121.7 infrastructure in Australia to be sufficient to effectively use any additional funds that come from multi-national or philanthropic investment, noting if this is not available then overseas funding cannot be accepted. Government is seen as having a clear role to ‘match private sector offers’ to provide for appropriate infrastructure
 - 5.121.8 staged and sustained public, private and philanthropic increased investment in R&D, possibly including benchmarking with other major innovative commercially successful industries and growth in R&D expenditure that is proportional to growth in health expenditure
 - 5.121.9 leveraging off foundations such as ‘Gates Grand Challenges’ in the philanthropic space
 - 5.121.10 recognition of the importance of global integration and interoperability.

- 5.122 Improving genomic diagnosis and treatment—for example, making gene space part of the 'Healthbook' concept.
- 5.123 All major Australian research institutions to have responsibility to develop partnerships with Indigenous communities to build the Indigenous health and medical research skill base and focus research on addressing major Indigenous health problems.

